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In the

# Supreme Court of the United States CLERK

DAVID MAXWELL-JOLLY, Director of the Department of Health Care Services, State of California, et al.,

*Petitioners,*

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.,

*Respondents.*

**On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit**

## PETITION FOR A WRIT OF CERTIORARI


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## QUESTIONS PRESENTED

Under 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act, a state that accepts federal Medicaid funds must adopt a state plan containing methods and procedures to "safeguard against unnecessary utilization of . . . [Medicaid] services and . . . assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population." The Ninth Circuit, along with virtually all of the circuits to have considered the issue since this Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), concluded that this provision does not confer any "rights" on Medicaid providers or recipients that are enforceable under 42 U.S.C. § 1983, and respondents do not contend otherwise. Nonetheless, in the present cases, the Ninth Circuit held that § 1396a(a)(30)(A) preempted several state laws that could have the effect (either directly or indirectly) of reducing Medicaid reimbursement payments to providers, because the California Legislature failed to conduct a specific type of study that the Ninth Circuit said was required.

The questions presented are:

1. Whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce § 1396a(a)(30)(A) by asserting that the provision preempts a state law that may reduce reimbursement rates.

## QUESTIONS PRESENTED – Continued

2. Whether a state law that could result in reduced Medicaid reimbursement to providers may be held preempted by § 1396a(a)(30)(A) based on requirements that do not appear in the text of the statute.

## LIST OF PARTIES

Petitioners are David Maxwell-Jolly, Director of the California Department of Health Care Services; John A. Wagner, Director of the California Department of Social Services; and Arnold Schwarzenegger, Governor of the State of California.

*California Pharmacists* respondents are California Pharmacists Association; California Medical Association; California Dental Association; California Hospital Association; California Association for Adult Day Services; Marin Apothecary, Inc., DBA Ross Valley Pharmacy; South Sacramento Pharmacy; Farmacia Remedios, Inc.; Acacia Adult Day Services; Sharp Memorial Hospital; Grossmont Hospital Corporation; Sharp Chula Vista Medical Center; Sharp Coronado Hospital and Healthcare Center; Fey Garcia; Charles Gallagher.

*Independent Living* respondents are Independent Living Center of Southern California, Inc.; Jerry Shapiro, Pharm. D., DBA Uptown Pharmacy & Gift Shoppe; Sharon Steen, DBA Central Pharmacy; Tran Pharmacy, Inc., a California Corporation.

*Dominguez* respondents are Lydia Dominguez; Patsy Miller; Alex Brown, by and through his mother and next friend Lisa Brown; Donna Brown; Chloe Lipton, by and through her conservator and next friend Julie Weissman-Steinbaugh; Herbert M. Meyer;

**LIST OF PARTIES** – Continued

Leslie Gordon; Charlene Ayers; Willie Beatrice Sheppard; Andy Martinez; Service Employees International Union United Healthcare Workers West; Service Employees International Union United Long-Term Care Workers; Service Employees International Union Local 521; and Service Employees International Union California State Council.

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## PETITION FOR A WRIT OF CERTIORARI

The Attorney General of the State of California, on behalf of David Maxwell-Jolly, Director of the California Department of Health Care Services (DHCS), John A. Wagner, Director of the California Department of Social Services (DSS), and Arnold Schwarzenegger, Governor of the State of California, respectfully petitions for a writ of certiorari to review four judgments of the United States Court of Appeals for the Ninth Circuit.

## OPINIONS BELOW

This petition seeks review of four opinions issued by a single panel of the Ninth Circuit Court of Appeals on March 3, 2010. Two of the opinions were designated for publication, App., *infra*, 1 (*Cal. Pharm. II*) and App., *infra*, 59 (*Dominguez*), but have not yet been reported, and two of the opinions were not designated for publication. App., *infra*, 37 (*Cal. Pharm. III*) and 53 (*Independent Living IV*). In one of the appeals (*Cal. Pharm. III*), the Ninth Circuit previously had issued an order granting an injunction pending appeal, App., *infra*, 42 (*Cal. Pharm. I*), which is reported at 563 F.3d 847. Three of the district court opinions that led to the Ninth Circuit decisions, App., *infra*, 84, 106, and 128, are reported at, respectively, 630 F. Supp. 2d 1144, 630 F. Supp. 2d 1154, and 603

F. Supp. 2d 1230, while the remainder are unreported. App. *infra*, 152, 161, 176, 178, 180.

## STATEMENT OF JURISDICTION

The Ninth Circuit issued the four opinions on March 3, 2010. App., *infra*, at 1, 37, 53, 59. Petitioners have not petitioned for rehearing or rehearing en banc. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

## CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution states:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const. art. VI, cl. 2.

The Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), states in pertinent part:

(a) Contents

A State plan for medical assistance must –

* * *

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. . . .

## INTRODUCTION

The present petition raises substantially the same legal issues as the petition for certiorari pending in *Maxwell-Jolly v. Independent Living Center of Southern California*, No. 09-958 (*Independent Living*). Those issues are (1) whether 42 U.S.C. § 1396a(a)(30)(A), a federal Medicaid statute that does not meet the criteria for private enforcement under 42 U.S.C. § 1983, may nonetheless be enforced against a state by private parties under a Supremacy Clause theory; and (2) whether a state statute that reduces Medicaid reimbursement to providers may be held preempted by § 1396a(a)(30)(A) based on criteria that do not appear anywhere in the statute.

In *Independent Living*, the primary basis for the Ninth's Circuit's preemption holding was the State's purported failure, before implementing a rate reduction, to conduct a study of the potential impact of Medicaid reimbursement reductions in light of the § 1396a(a)(30)(A) factors, and to study providers' costs in order to ensure that the reduced rates would bear a reasonable relationship to those costs. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) (*Indep. Living II*), *petition for cert. filed* (U.S. Feb. 16, 2010) (No. 09-958); *see also Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (*Indep. Living I*), *cert. denied*, 129 S. Ct. 2828 (2009) (holding that such claims could proceed under the Supremacy Clause). However, § 1396a(a)(30)(A) and its implementing regulations do not mention (let alone require) such a study, nor do they require any specific relationship between reimbursement payments and providers' costs. Moreover, the Ninth Circuit's analysis and holdings conflict with those of virtually every other circuit to have addressed these issues, namely, the First, Third, Fifth, Seventh, and Eighth Circuits.

In the present cases, the Ninth Circuit expanded its already atextual requirement of a study, holding, *inter alia*, that (1) a state must conduct a study of any reimbursement reduction not merely before implementing it, but also before *enacting* it (even though prior Ninth Circuit case law had permitted a reduction to be implemented while the requisite study was being conducted, *see Orthopaedic Hosp. v. Belshe*, 103

F.3d 1491, 1494 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998)); (2) the state *legislature*, rather than the relevant state agency, must conduct the study if the legislature was the entity responsible for imposing the reduction (so that formal, pre-enforcement studies conducted by DHCS could not discharge the State's purported duties under § 1396a(a)(30)(A)); (3) the study must *expressly reference both § 1396a(a)(30)(A) and the specific statutory enactment* at issue (so that a study prepared expressly for the state legislature that provides data from which the legislature could make an informed decision about a reduction, but that does not include the purportedly necessary express references, does not suffice); (4) a study prepared specifically for a state legislature does not suffice unless the state *produces evidence that the legislature actually considered it*, and that evidence must consist of more than a reference to the study in a legislative committee agenda; and (5) a state must study providers' costs prior to implementing any reduction even if a particular class of providers does not incur costs in providing their services, and must create a means for obtaining cost data if no such means already exists; however, if no provider cost data exists, a state may use a proxy, but the court may second-guess (and reject) the choice of proxy.

The Ninth Circuit issued these holdings in the context of challenges to two statutory enactments that occurred subsequent to the enactment at issue in *Independent Living*. *Independent Living* involves the Assembly Bill ("AB") 5 reductions: ten percent

across-the-board reductions in Medicaid reimbursement payments enacted in February 2008 to apply to services provided under Medi-Cal's[1] fee-for-service program on or after July 1, 2008 (the "AB5" reductions). App., *infra*, 190. As described below, the present petition involves two later enactments: (1) the "AB1183" reductions, enacted in September 2008 to replace the AB5 reductions, App., *infra*, 198; and (2) Senate Bill X3 6 ("SB6"), which concerns the State's contribution toward the hourly wage and benefits paid by counties to providers of In-Home Supportive Services (IHSS). App., *infra*, 218. On March 3, 2010, the Ninth Circuit panel that previously affirmed the injunctions in *Independent Living* also affirmed all the injunctions sought here (and in one case, *California Pharmacists III*, reversed the district court by ordering entry of an injunction that the court had declined to grant). App., *infra*, 1, 37, 53, 59.

As petitioner Maxwell-Jolly demonstrated in the *Independent Living* petition, the Ninth Circuit's decision to allow private enforcement of § 1396a(a)(30)(A), coupled with its willingness to impose ever-expanding atextual requirements, has created a new class of lawsuits that is wreaking havoc with California's ability to manage its $40 billion Medicaid budget and its ability to plan its way out of its budget crisis through sensible Medicaid reform. Untethered from

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[1] California's Medicaid program is known as Medi-Cal.

any statutory or regulatory language, the rules announced by the Ninth Circuit keep changing, and they become more onerous with each iteration. Congress put an administrative agency, rather than the courts, in charge of Medicaid for a reason: to work with the states on an ongoing basis, with regular communication and guidance, to ensure that they understand and comply with Medicaid requirements. Court-imposed injunctions, issued in private suits based on judicially-created, atextual requirements, that subject the States to massive liability, undermine Congressional intent and the cooperative federalism that is supposed to animate the program. These issues are important, recurring, national in scope, and the subject of conflicting and erroneous decisions among the circuits (as demonstrated in the *Independent Living* petition), and therefore merit review.

## STATEMENT OF THE CASE

On September 30, 2008, the Governor signed the AB1183 reductions into law. App., *infra*, 198. AB1183 enacted a new, substitute set of smaller reductions to take the place of the AB5 reductions starting on March 1, 2009. Specifically, it, *inter alia*, (1) replaced the prior 10% reduction applicable to payments to physicians, dentists, optometrists, and clinics under Medi-Cal's fee-for-service program with a smaller, 1% reduction for dates of service on or after March 1, 2009; (2) replaced the prior 10% reduction for

payments to Adult Day Health Centers (ADHCs) and pharmacies under Medi-Cal's fee-for-service program with a smaller, 5% reduction for dates of service on or after March 1, 2009; (3) replaced the prior 10% reduction applicable to payments to hospitals for outpatient services with a smaller, 1% reduction for dates of service on or after March 1, 2009; and (4) replaced the prior 10% reduction applicable to payments to hospital-based nursing facility services and hospital-based subacute care services with a smaller, 5% reduction for dates of service on or after March 1, 2009. AB1183 also repealed all payment reductions for small and rural hospitals effective November 1, 2008, and enacted a new reimbursement cap on payments to some noncontract hospitals for inpatient services provided on or after October 1, 2008. App., *infra*, 201-16; Cal. Welf. & Inst. Code §§ 14105.191(b)(1)-(3), 14166.245(b), (c).[2]

The Legislature directed DHCS to "promptly seek any necessary federal approvals for the implementation" of the reductions. App., *infra*, 205, 210, 215; Cal. Welf. & Inst. Code §§ 14105.19(g), 14105.191(h),

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[2] Specifically, payments for inpatient services provided by noncontract hospitals, other than small and rural hospitals, are subject to a 10% reduction under AB1183; in addition, those noncontract hospitals located in a Health Facility Planning Area (HFPA) with a specified minimum number of general acute care hospitals have their reimbursements capped at an average of rates paid to hospitals under contract with the State minus 5% ("CMAC-5%"). App., *infra*, 211, 214; Cal. Welf. & Inst. Code §§ 14166.245(b)(2)(A), (c)(3)(B).

14166.245(f). However, it authorized DHCS to "elect not to implement" the reductions on payments to fee-for-service providers if "federal financial participation is not available with respect to any payment" subject to the reductions. App., *infra*, 210; Cal. Welf. & Inst. Code § 14105.191(h). And it ordered DHCS and the California Medical Assistance Commission (CMAC) to report annually regarding the implementation and impact of the reductions on payments for inpatient services provided by noncontract hospitals. App., *infra*, 215-16; Cal. Welf. & Inst. Code § 14105.191(i).

On September 30, 2008, DHCS submitted a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services (CMS), which remains pending. That SPA encompassed the AB5 reductions and most of the superseding AB1183 reductions. *See* App., *infra*, 27.[3]

AB1183 prompted two of the lawsuits at issue, which were brought by different sets of providers: *California Pharmacists Association v. Maxwell-Jolly* and *Independent Living Center of Southern California v. Maxwell-Jolly* (*Independent Living IV*). A separate enactment, SB6, prompted a third lawsuit, *Dominguez v. Schwarzenegger*. Each is described in turn.

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[3] In response to a request from CMS, DHCS subsequently split the September 30, 2008 SPA into four separate SPAs that it submitted on October 29, 2008. DHCS submitted a separate SPA to encompass the AB1183 reductions for noncontract hospital inpatient services on December 31, 2008.

***California Pharmacists v. Maxwell-Jolly***

On January 29, 2009, Medicaid provider groups and beneficiaries filed *California Pharmacists Association v. Maxwell-Jolly* to enjoin the 1% and 5% reductions applicable to fee-for-service providers, including pharmacies, ADHCs, and hospital-based nursing facilities and subacute care facilities, and the new (CMAC-5%) reimbursement cap on inpatient services provided by certain noncontract hospitals. *See* App., *infra*, 205-06, 211, 214; Cal. Welf. & Inst. Code §§ 14105.191(b)(1)-(3), 14166.245(b)(2)(A), (c)(3)(B). Respondents moved for preliminary injunctions shortly thereafter. In opposing the motions, DHCS submitted a broad array of evidence concerning the legislative process that led to the enactments and analyzing the adequacy of the reduced rates.

Declarations described the California Legislature's deliberative process in enacting AB1183. Starting in January 2008, top-ranking DHCS officials in charge of Medi-Cal met with the Governor's Office and members of the Legislature to discuss the options available for reducing the ever-increasing costs of the Medi-Cal program. The more moderate proposed reductions ultimately enacted by AB1183 were considered and discussed in legislative committee meetings in May, June, and July 2008, as documented in committee reports and agendas. App., *infra*, 18-20, 98, 119. A sworn declaration from DHCS's Deputy Director for Legislative and Governmental Affairs described how DHCS staff members provided information, technical assistance, and responses to numerous

inquiries from legislative staff members concerning the reductions from May 2008 until AB1183 was enacted in September 2008. App., *infra*, 18. Ultimately, the Legislature and Governor were able to avoid taking more draconian measures, such as eliminating all optional Medi-Cal benefits including pharmacy services (which cost Medi-Cal in excess of $3 billion per year)[4] or restricting beneficiaries' eligibility for Medi-Cal.

Cognizant of the Ninth Circuit's prior rulings in *Independent Living I* and *Orthopaedic*, following AB1183's enactment but before its implementation, DHCS conducted formal cost-based evaluations with respect to those services for which it could obtain relevant cost data. Based in part on these evaluations, DHCS prepared a series of formal reports analyzing the potential impact of each of the AB1183 reductions, which it released in February 2009, before most of the AB1183 reductions took effect on March 1, 2009.[5] DHCS concluded in these reports, based on its

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[4] "Optional" benefits are those that, under the Medicaid Act, a state may, but is not required, to provide. California eliminated coverage for some optional benefits effective July 1, 2009, but preserved coverage for ADHC services, prescription drugs, substance abuse treatment services, licensed midwife services, hearing aids, Personal Care Services Program, and other services.

[5] By statute, the AB1183 reduction applicable to certain noncontract hospitals' inpatient services was implemented in October 2008, before the other AB1183 reductions. Therefore, one study, "Amended Analysis: Impact of Welfare and Institutions Code Section 14166.245 Concerning Medi-Cal Reimbursement

(Continued on following page)

analysis and the data available to it, that the reduced payments would comply with federal law, reasonably compensate providers' costs, increase efficiency in Medi-Cal, and not impair beneficiaries' access to services. Although the methods and data used in each analysis varied, DHCS noted in *all* the reports that, during the period in which the higher 10% reductions were in effect, there were no material declines in either claims paid or the number of providers participating in Medicaid, supporting the conclusion that the new, far-smaller reductions were unlikely to disrupt the system. *See, e.g.*, App., *infra*, 100.

**ADHCs.** DHCS submitted a February 24, 2009 report entitled "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Adult Day Health Care Centers." *See* App., *infra*, 96-97, 99-100. In the report, DHCS concluded that reimbursement to ADHCs, as reduced by AB1183, would be sufficient to cover at least 100% of their necessary and reasonable costs and would not result in any access problem. *See* App., *infra*, 97, 99. DHCS based its analysis in part on cost data for nursing (level A) facilities (NF-As) because, as it explained, it does not have access to reliable cost data for ADHCs.[6] App., *infra*, 99 n.6. Instead,

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for Non-Contract Hospital Inpatient Services," described in more detail below, was issued after the implementation date for the relevant reduction.

[6] Due to recent state legislation, DHCS is developing a cost-based reimbursement methodology for such entities that will be effective August 1, 2012. *See* Cal. Welf. & Inst. Code §14571.2; App., *infra*, 99 n.6

pursuant to a court settlement to which ADHCs were a party, on August 1, 1997, the Medi-Cal reimbursement daily rate for ADHCs was set at 90% of the statewide weighted average of the Medi-Cal daily rate for NF-As (who are reimbursed at least 100% of their costs), although due to subsequent adjustments, the relationship is now closer to 87%. For context, ADHCs typically provide only four hours of services a day to a population that is far more ambulatory and independent than the population served by NF-As, which generally requires 24-hour nursing care in an institutional setting. Moreover, there has been a threefold increase in ADHCs since 1997, when their reimbursement rates were linked to NF-As.

**Hospital-Based Nursing Facility and Subacute Care Services.** DHCS submitted a February 24, 2009 Report, entitled "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Various Nursing Facility Services." This was a 12-page report with supporting material. Based on a study of costs incurred by these providers, DHCS determined that, after a 5% reduction, reimbursement would compensate in the aggregate 86-92% of costs incurred by adult subacute care providers, 104-109% of the costs incurred by pediatric subacute care providers, and 83-85% of costs incurred by hospital-based nursing facility (level B, or NF-B) providers. DHCS noted that, with respect to NF-B services, other providers that are not subject to the AB1183 reductions (i.e., freestanding nursing facilities) currently provide 94% of such services at about half the expense.

**Noncontract Hospitals Inpatient Services.** DHCS produced a February 19, 2009 report entitled "Amended Analysis Impact of Welfare and Institutions Code Section 14166.245 Concerning Medi-Cal Reimbursement for Non-Contract Hospital Inpatient Services." App., *infra*, 117. This was a 16-page report with 130 pages of supporting material.[7] In the report, DHCS concluded that, after the AB1183 reductions, Medi-Cal reimbursement would compensate in the aggregate 91% of the costs incurred by all noncontract hospitals, with many noncontract hospitals being reimbursed 100% or more of their costs.[8] DHCS explained, further, that the reductions would incentivize noncontract hospitals to enter into contracts with the State, resulting in tremendous cost efficiencies. While noncontract hospitals provide approximately 11% of inpatient days, they receive 21.9% of Medi-Cal reimbursement for hospital inpatient services. The State saved $572 million in the 2007-2008 fiscal year due to the reduced rates it pays to contract hospitals, and has saved over $10.3 billion in general fund expenditures since 1983. DHCS also concluded that the reductions would not create patient access problems, in part because contract hospitals that are

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[7] The February 19, 2009 report corrected errors in the original report issued on January 29, 2009.

[8] Many noncontract hospitals receive, in addition to the reimbursement paid pursuant to AB1183, supplemental Medi-Cal reimbursement under the disproportionate share hospital (DSH) program. AB1183 did not reduce Medi-Cal money paid to noncontract hospitals under the DSH program.

not subject to the AB1183 reductions on inpatient services provide 89-90% of those services under Medi-Cal. *See* App., *infra*, 125-26.

**Hospital Outpatient Services.** DHCS did not prepare a formal report analyzing AB1183's impact on outpatient services, instead submitting declarations and supporting documents. Based on historical claims data (including the claims and participation data for when the 10% reduction was in effect), DHCS demonstrated that the 1% reduction mandated by AB1183 would not reduce Medicaid beneficiaries' access to such services.

DHCS did not analyze how the reduced rates would compare to providers' costs in providing outpatient services because, as it explained, there is no feasible mechanism for collecting reliable cost data for each of the 20,000-plus outpatient services covered by Medi-Cal. Following the Ninth Circuit's decision in *Orthopaedic*, DHCS commissioned a consulting firm, Tucker-Alan, Inc., to develop a methodology. After two failed attempts, the outside consultant advised that development of a sufficiently reliable cost model would take 5-7 years to establish and implement. Ultimately, rather than develop a cost model, DHCS entered into a settlement agreement with the hospitals under which their outpatient reimbursement increased substantially (e.g., by 44.34% in July 2004 above what was in effect in June 2001). *See* App., *infra*, 125.

DHCS also submitted a Legislative Analyst's Office (LAO) report, "Analysis of the 2008-09 Budget Bill" (2008-09 Analysis),[9] which evaluated the 10% reduction enacted by AB5 and, *inter alia*, recommended more moderate reductions for some services (a recommendation that the Legislature ultimately followed when it enacted AB1183). The LAO is a nonpartisan entity, operating under the oversight of the Joint Legislative Budget Committee, to "provid[e] fiscal and policy advice to the Legislature." *See* http://www.lao.ca.gov/laoapp/laomenus/lao_menu_aboutlao.aspx. The LAO report recommended increased reductions for hospitals on the ground that they have "received significant rate increases relative to other provider types in recent years, and hospitals are generally among the most expensive settings to provide care." App., *infra*, 125. The Legislature followed that recommendation by enacting lower rates for some noncontract hospitals, although it eliminated any reduction for small and rural hospitals.

On March 9, 2009, in *California Pharmacists*, the district court enjoined the 5% reduction on ADHCs, App., *infra*, 84, but refused to enjoin the AB1183 reductions as to inpatient, outpatient, and other services provided by hospitals, holding that plaintiffs had failed to carry their burden on irreparable harm. App., *infra*, 106. The district court held that plaintiffs

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[9] The LAO's 2008-09 Analysis is available at http://www.lao.ca.gov/analysis_2008/health_ss/healthss_anl08.pdf.

had demonstrated a likelihood of success on *all* their claims based on the State's failure to discharge a purported duty under § 1396a(a)(30)(A), as interpreted by the Ninth Circuit, to study the impact of any rate reduction before the reduction is enacted. App., *infra*, at 98-99, 120. The district court specifically faulted DHCS's formal study on ADHCs for utilizing NF-A data, "which may not be an adequate proxy for ADHC costs." App., *infra*, 99. While the court recognized that the LAO report supported the reductions for noncontract hospitals, the court held it was insufficient because "defendant presents no evidence to indicate that the Legislature actually reviewed or considered the LAO's report in passing AB1183." App., *infra*, at 119 n.8.

After the district court denied their motion for a preliminary injunction based on their failure to demonstrate irreparable harm, the hospital plaintiffs filed an emergency motion for a preliminary injunction pending appeal in the Ninth Circuit. On April 6, 2009, the Ninth Circuit granted an injunction pending appeal. App., *infra*, 42 (*Cal. Pharm. I*). It agreed that the hospitals had demonstrated a likelihood of success on the merits given the State's failure to show that the Legislature considered the § 1396a(a)(30)(A) factors before passing AB1183. App., *infra*, 44-45. Specifically, it found no abuse of discretion in the district court's holdings that (1) DHCS's formal studies were impermissibly post hoc; and (2) evidence that the LAO had recommended enactment of the rate reductions was inadequate because "there was

no evidence that the Legislature actually considered the report before enacting AB1183." App., *infra*, 44-45. In addition, the court found that respondents had demonstrated irreparable injury given that the Eleventh Amendment would bar them from obtaining retroactive monetary damages were they ultimately to prevail in the case. App., *infra*, 50.

On March 3, 2010, the Ninth Circuit issued opinions affirming the injunctions of the payment reductions for ADHCs (*Cal. Pharm. II*), and reversing the denial of an injunction of payment reductions for noncontract hospitals (*Cal. Pharm. III*). App., *infra*, 1, 37. The Ninth Circuit emphasized that, under *Independent Living II*, the State must produce evidence that it studied the impact of any rate reduction on the § 1396a(a)(30)(A) factors *before* the reduction either is enacted *or* implemented, and that the State relied upon responsible cost data in setting rates. App., *infra*, 3, 15-17, 36. Further, the court held that, because the California Legislature was the entity that mandated the payment reductions, it, rather than DHCS, was the entity that "must engage in the same principled analysis we required of the Director in *Orthopaedic II*." App., *infra*, 13-14; *see also* App., *infra*, 16-17 ("[W]e find nothing remarkable in holding that the final body responsible for setting Medicaid reimbursement rates must study the impact of the contemplated rate reduction on the statutory factors . . . *prior* to setting or adjusting payment rates.").

Despite uncontroverted evidence that the California Legislature had considered and discussed the AB1183 rate reductions before enacting them, the court held that the State failed to demonstrate that the Legislature had discharged its obligations under § 1396a(a)(30)(A). The court noted that, while the agendas and other legislative documents provided by DHCS referenced the specific rate reductions, they did not expressly reference the § 1396a(a)(30)(A) factors, and therefore could not serve as evidence that the Legislature expressly considered those factors. App., *infra*, 20 ("[T]he legislative history nowhere mentions any of the § 30(A) factors."). In addition, according to the panel, there was no evidence that the Legislature relied on "'"responsible cost studies, its own or others,"'" as a basis for its rate-setting. App., *infra*, 20-21 (quoting *Independent Living II* and *Orthopaedic*).

The court rejected as inadequate the post-enactment, but largely pre-implementation, formal studies that DHCS released in February 2009. It explained that, "[t]o satisfy § 30(A), any analysis of reimbursement rates . . . must have the potential to influence the rate-setting process." App., *infra*, at 22. The post-enactment studies could not suffice because, according to the court, AB1183 was phrased in mandatory terms and did not give DHCS discretion *not* to implement the rates based on the results of its analysis. App., *infra*, 22. The court rejected DHCS's arguments that, under federal and state law, as the designated "single state agency" entrusted with

implementing Medicaid, it could have declined to implement the reductions pursuant to California Welfare and Institutions Code sections 14105(a) and 14105.191(i). App., *infra*, 22-26; *see also* 42 U.S.C. § 1396a(a)(5).

With respect to ADHCs, the panel held that the district court did not abuse its discretion in rejecting NF-A cost data as a proxy for ADHC cost data, App., *infra*, 29, even though reliable ADHC cost data was not available to DHCS when it conducted its analysis, and even though ADHCs reimbursement rates have been tied to NF-A reimbursement rates since 1997.

### *Independent Living v. Maxwell-Jolly* (*Independent Living IV*)

On January 16, 2009, a group of pharmacy plaintiffs filed a lawsuit, *Managed Pharmacy Care v. Maxwell-Jolly*, to enjoin a 5% rate reduction for pharmacy services rendered on or after March 1, 2009 under Medi-Cal's fee-for-service program, pursuant to AB1183. *See* App., *infra*, 206; Cal. Welf. & Inst. Code § 14105.191(b)(3). Shortly thereafter, respondents moved for a preliminary injunction.

DHCS produced a wide array of evidence to oppose this injunction, including much of the same legislative material it provided in *California Pharmacists*. Of particular relevance to the pharmacy reductions, DHCS produced an agenda for a May 30, 2008 meeting of the Assembly Budget Subcommittee No. 1 on Health and Human Services that expressly

referenced a pharmaceutical cost-data study (the "Myers and Stauffer" study). App., *infra*, 55.

In addition, DHCS produced its February 8, 2009 report entitled "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Pharmacies." App., *infra*, 141. This was a 13-page report with over 150 pages of supporting material. Included among them was the above-referenced Myers and Stauffer report, an analysis of drug dispensing and acquisition costs incurred in California prepared by an outside accounting firm that specializes in Medicaid issues. Based on this report, and adjusting for inflation, DHCS concluded that, as of March 1, 2009, Medi-Cal would reimburse drugs in the aggregate (i.e., single source drugs and multisource drugs) at 108.7% of costs without the AB1183 reductions, and at 103% of costs after the reductions were imposed (98.9% of costs for single source drugs, and up to 137% of costs for multisource drugs). *See* App., *infra*, 147, 159. More efficient pharmacies would do even better. There would be no access problem, as 5,772 of the 6,078 pharmacies in California with active licenses are actively enrolled in Medi-Cal.

On February 27, 2009, the district court enjoined the 5% reduction on payments for prescription drugs. App., *infra*, 128; *see also* App., *infra*, 152 (denying motion to alter or amend, and clarify prior order). The district court's analysis was substantially the same as that in its *California Pharmacists* decision described above.

On March 3, 2010, the Ninth Circuit affirmed the district court's order enjoining the AB1183 reduction for pharmacies. App., *infra*, 53. It reiterated much of the reasoning from its *California Pharmacists* opinion with respect to the purported requirement of a *pre-enactment* study conducted by the state *legislature*. App., *infra*, 54, 57. Although it acknowledged the express mention of the Myers and Stauffer report in the budget committee agenda, the court rejected this evidence as inadequate under § 1396a(a)(30)(A): "the one-sentence citation to the May 30, 2008 agenda does not show adequate consideration of the § 30(A) factors." App., *infra*, 55-56. The court also found the Myers and Stauffer report inadequate because "it is bereft of any analysis of the remaining § 30(A) factors – efficiency, economy, quality, and access to care." App., *infra*, 56.

### *Dominguez v. Schwarzenegger*

In February 2009, the Governor signed the SB6 reductions into law. App., *infra*, 218. Effective July 1, 2009, SB6 would have reduced an existing cap on the State's maximum contribution to wages and benefits paid by the counties to IHSS providers as part of Medi-Cal. App., *infra*, 224; Cal. Welf. & Inst. Code § 12306.1(d)(6).

The IHSS program provides payment for services such as cleaning, personal care services, accompaniment for necessary travel to health-related appointments, and protective supervision, to low-income,

aged, blind and disabled persons. *See* Cal. Welf. & Inst. Code § 12300. The IHSS program is administered by the California counties, and the wages paid to IHSS providers are generally governed by collective bargaining agreements negotiated by the counties with unions representing IHSS providers, to which the State is not a party. App., *infra*, 63-64, 163-64. Because they are separately negotiated, the rates paid for IHSS wages vary from county to county. The State contributes 65% of the nonfederal share of wage and benefits paid to IHSS providers, up to a statutory cap, which was $12.10 per hour before SB6 was enacted (the counties pay the remaining 35% of the nonfederal share). App., *infra*, 65, 163-64.

Under SB6, the statutory cap toward which the State was to contribute would have been reduced from $12.10 to $10.10 per hour effective July 1, 2009. App., *infra*, 65, 224; Cal. Welf. & Inst. Code § 12306.1(d)(6). This amendment would not have affected the majority of counties or the majority of IHSS providers: before the Legislature enacted SB6, 36 of the State's 58 counties already paid IHSS providers $10.10 or less per hour in wages and benefits, including Los Angeles County, where 42% of all IHSS services are provided. *See* App., *infra*, 66, 164-65. Further, counties always have had the option of paying more than the maximum amount to which the State will contribute, and would have been free to do so in this instance, using their own funds as necessary to pay the nonfederal share. App., *infra*, 66, 164.

Respondent unions and Medi-Cal beneficiaries filed *Martinez v. Maxwell-Jolly*, on May 26, 2009, challenging implementation of the new cap. They contended that the new cap was preempted by § 1396a(a)(30)(A) because the State purportedly failed to study its impact before enacting it.

Petitioners conceded that the Legislature had not specifically conducted a study analyzing the impact of SB6 on the § 1396a(a)(30)(A) factors before the reductions were enacted. The new participation cap was, after all, equal to or higher than the wages and benefits already in effect in most of the State. Petitioners noted, however, that when the Legislature enacted SB6, it had access to the "July 2008 Report to the Legislature, Public Authorities and Nonprofit Consortia in the Delivery of In-Home Supportive Services, SFY 2006/2007" (July 2008 report), a type of report that the Department of Social Services (DSS) must submit on an annual basis. App., *infra*, 78, 80. In the words of the Ninth Circuit, this report contained "extensive data regarding quality and access in the IHSS system," App., *infra*, 78, including data on the number of providers available to work in the provider registries in each county; data on service shortages and the availability of emergency back-up providers; and data on wages and benefits paid by each county.

On June 25, 2009, the district court enjoined the reduced cap imposed by SB6. App., *infra*, 161, 176; *see also* App., *infra*, 178, 180 (amended injunction, order clarifying injunction). It, too, cited petitioners' failure

to produce evidence demonstrating that the California Legislature considered the § 1396a(a)(30)(A) factors when it adopted the new cap. App., *infra*, 171-72. The district court also found that respondents met their burden to show irreparable harm based on evidence that, were the rates reduced, IHSS providers might leave the program, possibly leaving some beneficiaries with reduced services. App., *infra*, 172-73.

On March 3, 2010, the Ninth Circuit affirmed the injunction in an opinion at issue here. App., *infra*, 59 (*Dominguez*). The court recognized that SB6 does not directly reduce IHSS wages, but merely may lower the State's contribution to those wages. App., *infra*, 70. Nonetheless, the court held that, "before enacting legislation that has the effect of lowering payments to providers . . . the State must study the impact of the decision on the statutory factors set forth in §30(A)." App., *infra*, 70 (citing *Cal. Pharm. II*). The court rejected petitioners' arguments that they could not study IHSS providers' costs because such providers do not incur costs. The court held that, where the court has previously required a cost study, the State is not immunized from liability simply because it has no mechanism for collecting such costs (or, apparently, even though such costs do not exist). App., *infra*, 77. Instead, the court said the state "must rely on something." App., *infra*, 78. It therefore suggested that the State "look to what it costs providers of analogous services, such as in-home nursing care, as a means of considering providers' costs." App., *infra*,

78-79. Although the State demonstrably did rely on "something" in defending SB6 in its Ninth Circuit briefing – specifically the July 2008 report to the Legislature – the court held that this too was inadequate to discharge the State's duties under § 1396a(a)(30)(A) because it did not specifically reference SB6, "let alone 'study the impact of the contemplated rate change(s) on the statutory factors *prior to* setting rates, or in a manner that allows those studies to have a meaningful impact on rates before they are finalized.'" App., *infra*, 80 (quoting *Cal. Pharm. II*).

The court also rejected petitioners' arguments that SB6 would not result in an access problem, noting that under its prior decisions, the obligations under § 1396a(a)(30)(A) are purely "procedural." App., *infra*, 76. It thereby reaffirmed its holding in *Independent Living II* that a state law may be enjoined solely because the State failed to conduct a particular kind of study, regardless of whether the measure complies "substantively" with federal law, and despite the fact that neither § 1396a(a)(30)(A) nor its implementing regulations requires such a study.

## REASONS FOR GRANTING THE PETITION

1. The Court should grant the petition to consider whether a private party may bring a preemption challenge under a Spending Clause statute, 42 U.S.C. § 1396a(a)(30)(A), that is not otherwise

enforceable by private parties under 42 U.S.C. § 1983. This issue is already pending before this Court in the petition for certiorari filed in *Independent Living II* and *III*, No. 09-958.

Under the reasoning adopted by the Ninth Circuit, a private party may seek to enforce any federal statute, and enjoin state conduct, merely by invoking the Supremacy Clause and alleging a conflict between state and federal law. A party pursuing such a theory need not satisfy any of the requirements for private enforcement of federal statutes that this Court has carefully crafted and applied over several decades, such as the requirement that the party demonstrate that Congress intended to create a privately enforceable federal "right" and that the provision to be enforced is not so "vague and amorphous" as to strain judicial competence. *See, e.g., Cort v. Ash*, 422 U.S. 66 (1975); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981); *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002).

The Ninth Circuit's theory (which the D.C., Fifth, and Eighth Circuits also have accepted[10]) has opened the door to a flood of lawsuits seeking to enjoin state action based on federal Spending Clause provisions

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[10] *See Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 330-35 (5th Cir. 2005); *Lankford v. Sherman*, 451 F.3d 496, 509-13 (8th Cir. 2006); *see also Pharmaceutical Res. & Mfrs. of Am. (PhRMA) v. Thompson*, 362 F.3d 817, 819 n.3 (D.C. Cir. 2004); *cf. PhRMA v. Concannon*, 249 F.3d 66, 73 (1st Cir. 2001).

that previously have been held by the courts to be unenforceable by private parties under § 1983, including 42 U.S.C. §§ 1396a(a)(17) and 1396a(a)(30)(A). *See* App., *infra*, 228. One recent lawsuit even sought to invoke *Independent Living* and the Supremacy Clause to state a claim under a purely hortatory "purposes" provision of the American Recovery and Reinvestment Act of 2009, H.R. 1, 111th Cong., Pub. L. No. 111-5 (1st Sess. 2009), § 5000(a). *Gray Panthers of San Francisco v. Schwarzenegger*, No. C 09-2307 PJH, 2009 WL 2880555 (N.D. Cal. Sept. 01, 2009).

Recent developments, including the four new opinions at issue here, confirm both the recurring nature and national importance of the question presented. As reflected in the updated information included in the Appendix, App., *infra*, 228, the Ninth Circuit's *Independent Living* decisions have generated almost 40 new lawsuits across the country, including in Arizona, Connecticut, Delaware, Hawai'i, Idaho, Kansas, Louisiana, Maine, Minnesota, New York, Pennsylvania, and Washington. California's liability under existing injunctions is fast approaching $1 billion, consisting of over $735 million in lost Medicaid savings to date, and more than $250 million in additional retroactive relief to which providers in *Independent Living* contend they are entitled. App., *infra*, 228-32. The existing injunctions are costing over $35 million in additional lost Medicaid savings each month that they remain in place. App., *infra*, 228-32. More can be expected: in the short time since

petitioner Maxwell-Jolly filed the petition for certiorari in *Independent Living* in February 2010, two more courts in California have issued injunctions based on the Ninth Circuit's interpretation of the Supremacy Clause. App., *infra*, 228, 229.

Petitioners believe that *Independent Living* is a suitable vehicle for deciding this first question presented, as the Ninth Circuit chose that opinion to announce its holding and analysis. Moreover, the Ninth Circuit declined to revisit this issue in the four March 3, 2010 opinions at issue here, apparently believing that its earlier decisions in *Independent Living I, II,* and *III* resolved it. However, as DHCS has noted, while the petition for certiorari in *Independent Living* presents a live case or controversy, the state statute at issue in those decisions is no longer in effect, having been replaced with the lower (AB1183) reductions at issue here.[11] Therefore, if this Court would prefer to decide the question presented with respect to reductions that are still in effect, the present petition presents an excellent vehicle for doing so. Petitioners properly preserved this first

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[11] The petition in *Independent Living* presents a live controversy because, if the State prevails, it will be entitled to retroactive reimbursement of excess Medicaid reimbursements that it was required to pay providers as a result of the injunctions at issue in that case.

question presented in both *Dominguez* and *Independent Living IV*.[12]

2. The Court also should grant the petition to consider whether state statutes that directly (or, at best, indirectly in the case of SB6) reduce Medicaid reimbursement payments to certain providers may be preempted based on requirements that do not appear in the text of the preempting federal statute, § 1396a(a)(30)(A). This issue, too, is already pending before this Court in the *Independent Living* petition for certiorari, No. 09-958.

In *Independent Living*, the Ninth Circuit held that the AB5 reductions were preempted because California failed to provide evidence that, "before implementing those cuts," it (1) studied the impact of

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[12] In *Dominguez*, petitioners preserved this issue as presented here. In *Independent Living IV*, petitioners included this argument in a discussion in their opening brief of "prudential standing," expressly stating: "It is the Department's position that *ILC* was wrongly decided because it conflicts with numerous Supreme Court precedents, including *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), and because the Supremacy Clause does not itself create any substantive rights. *See Dennis v. Higgins*, 498 U.S. 439, 450 (1991); *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 33 103, 107 (1989); *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 615 (1979). The Department recognizes, however, that *ILC* is controlling here, and therefore raises these arguments to preserve them for later appellate proceedings." Defendant-Appellant David Maxwell-Jolly's Opening Brief and Request for Oral Argument at 32-33, *Indep. Living IV*, No. 09-55692 (9th Cir. June 19, 2009) (footnote omitted); *see also* App., *infra*, 138 n.6 & 171 n.5.

the reductions on the § 1396a(a)(30)(A) factors of efficiency, economy, quality, and access to care; and (2) considered responsible studies of providers' costs, to ensure that the reduced rates would bear a reasonable relationship to those costs. *Indep. Living II*, 572 F.3d at 648, 651-52. However, neither §1396a(a)(30)(A), nor any of its implementing regulations, requires any sort of study, let alone a pre-enactment or pre-implementation study; and neither §1396a(a)(30)(A), nor any of its implementing regulations, requires that reimbursement rates bear any relation to providers' costs. The Ninth Circuit also held that the rate reduction could be preempted because it was motivated "solely" by "budgetary concerns." *Id.* at 655-56. But § 1396a(a)(30)(A) does not preclude a state from reducing rates to address a budgetary crisis, so long as the substantive requirements of the statute are met.

In the present cases, the Ninth Circuit reaffirmed this basic framework, and then added to it. Based on the new decisions:

(1) Any study must be concluded not merely pre-implementation, but also pre-enactment (resolving an ambiguity in *Independent Living II* and *III*). App., *infra*, 15, 54, 57, 80.

(2) The actual entity that mandates the payment reductions – in this case, the California Legislature – must conduct the required study. App., *infra*, 13-14, 16, 54.

(3) Where the obligation to conduct the study falls on a state legislature rather than a state agency, there must be evidence that the legislature actually considered the requisite study. Something more than an agenda item reflecting that a budget committee studied the issue is required. App., *infra*, 55-56. A report issued by a nonpartisan entity convened by the state legislature to assist in fiscal and budgeting matters also does not suffice, absent additional evidence that the legislature considered the report. App., *infra*, 45. While the Ninth Circuit rejected this evidence, it did not indicate what *would* be adequate evidence that the Legislature had discharged its duty under § 1396a(a)(30)(A) as interpreted.

(4) Any study must expressly reference both the state enactment being analyzed (e.g., SB6, AB1183) *and* the § 1396a(a)(30)(A) factors. App., *infra*, 20, 56, 80. Thus, evidence that a state legislature considered reports or data that did not specifically reference either the reductions or § 1396a(a)(30)(A), but from which the legislature reasonably could have drawn the conclusion that the reductions would comply with federal law, does not suffice.

(5) If a state does not have a feasible means for obtaining cost data with respect to a specific type of cut, it must obtain such data or possibly rely on a reasonable proxy. App., *infra*, 78-79 (suggesting that State use in-home nursing care costs as proxy for IHSS providers, even though IHSS providers do not incur costs). However, the court may second-guess (and reject) the proxy chosen by the state. App., *infra*,

29 (suggesting that DHCS should not have used NF-A cost data as a proxy in the ADHC study, even though ADHC reimbursement rates have been tied to NF-A reimbursement rates since 1997).

In addition, the Ninth Circuit reaffirmed that, even if there is evidence that rates under the challenged state statute will remain substantively adequate under § 1396a(a)(30)(A), such evidence may be irrelevant: the statute still may be enjoined if the State failed to comply with a "procedural" requirement to produce a pre-enactment study that contains all the features set forth above. App., *infra*, 76; *see also* App., *infra*, 22.

In light of the ever-growing list of increasingly specific requirements that the Ninth Circuit has imposed under the guise of interpreting § 1396a(a)(30)(A), it is at best ironic that the court chose to "emphasize that the State need not follow 'any prescribed method of analyzing and considering [the § 30(a)] factors.'" App., *infra*, 17 (quoting *Minn. HomeCare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam)). Presumably cognizant that it is on the short side of a circuit split concerning whether states must conduct a § 1396a(a)(30)(A)-based study before implementing Medicaid rate reductions,[13] the court apparently

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[13] *Compare Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 56 (1st Cir. 2004); *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 933 n.33 (5th Cir. 2000), *overruled in part on other grounds*, *Equal Access for El Paso, Inc. v.*

(Continued on following page)

sought thereby to characterize its approach as somewhere within the judicial mainstream. But, as DHCS demonstrated in its petition for certiorari in *Independent Living*, the Ninth Circuit's approach was already an outlier, in terms of the scope and onerous nature of the atextual requirements that it imposed, *before* it issued this latest series of decisions. These new decisions add yet more, increasingly detailed, requirements for a study that no federal statute or regulation requires. And no other Circuit has imposed duties directly on a state *legislature* under § 1396a(a)(30)(A). *See Minn. HomeCare*, 108 F.3d at 919 (Loken, J., concurring) ("Federal courts do not undertake administrative law review of legislative action, certainly not the action of a state legislature.").[14]

The Ninth Circuit's decisions in the present cases further underscore the need for this Court's intervention, whether in *Independent Living* or here. The decisions illustrate why preemption of state statutes

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*Hawkins*, 509 F.3d 697, 704 (5th Cir. 2007), *cert. denied*, 129 S. Ct. 34 (2008); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); *Minn. HomeCare*, 108 F.3d at 918 *with Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993).

[14] The Ninth Circuit's citation to *Minnesota HomeCare* also is ironic because the Eighth Circuit there affirmed summary judgment in the State's favor despite the fact that "DHS did not provide any formal analysis of the equal access factors to the legislature" in connection with the rate change at issue. 108 F.3d at 918.

based on conflicts with judicially created funding conditions that have no textual support in the preempting federal statute is completely unworkable, in addition to conflicting with this Court's discussion in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981) regarding the nature of Spending Clause legislation. *Id.* at 17 ("[I]f Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously."). By adopting inconsistent, ever-expanding, ever-more-detailed rules, the Ninth Circuit has made it virtually impossible for California to enact a statute that directly (or at best, indirectly) may reduce reimbursements to Medicaid providers.

To recap the relevant history, the first decision in the series, *Orthopaedic*, required the State to "rely on responsible cost studies, its own or others," in setting rates, but did not require any study to be completed pre-implementation; rather, the State was permitted to implement the rate reductions while its cost analysis was underway. *See* 103 F.3d at 1494. To comply with *Orthopaedic*, in *Independent Living*, DHCS submitted declarations that analyzed the impact of the rate reductions on the § 1396a(a)(30)(A) factors, and on providers' costs, including cost data where it was available. But this was held insufficient because the Ninth Circuit held in *Independent Living II* that any studies must occur "before implementing [any] cuts," 572 F.3d at 648, and suggested, in a footnote, that they must be prepared "in anticipation" of the rate reduction. *Id.* at 652 n.9.

At the time that the cases at issue here were briefed in the district court, *Independent Living II* had not yet been decided. But the State was aware of the *Orthopaedic* decision, and also knew, based on the district court's willingness to enter an injunction in *Independent Living*, that relying on post-implementation declarations probably would not suffice to support AB1183 and SB6. To comply with then-existing Ninth Circuit precedent, therefore, in opposing the injunctions, the State produced a variety of material to the district courts, including formal reports discussing the specific reductions in light of the § 1396a(a)(30)(A) factors, and materials available to the Legislature when it deliberated. It is fairly indisputable that these materials would have sufficed under *Orthopaedic* – or, if not, at least the State would have been permitted to conduct additional analysis while the reductions remained in place.

However, none of this was enough under the new, expanded parameters announced by the Ninth Circuit in the present cases. When DHCS, as *the single state agency* designated under federal and state law to implement Medicaid in California, performed *pre-implementation* formal studies analyzing the impact of the specific reductions on the § 1396a(a)(30)(A) factors, the court rejected such studies as untimely and because the wrong entity conducted them. When the State produced evidence that the *Legislature* considered a *pre-enactment* analysis of pharmacies' costs (the Myers and Stauffer report), the court rejected that evidence because the proof that the

Legislature considered the report consisted of only "one-sentence" in a budget committee agenda. When the State produced evidence of *pre-enactment* analyses *prepared specifically for the Legislature* (the IHSS report prepared by DSS, and the LAO report recommending reduction of hospital reimbursements), the court found there was insufficient evidence that the Legislature actually considered them, and also held the analyses inadequate because they did not specifically mention either the preempting statute (§ 1396a(a)(30)(A)) or the state reduction (AB1183, SB6).

This is not what Congress intended. A state cannot run a $40 billion Medicaid program where every decision is potentially subject to private enforcement through court-imposed injunctions. To the contrary, Congress envisioned a program of cooperative federalism, under which the States are in constant communication with a federal agency, CMS, to receive guidance and to ensure compliance with federal law. However, the Ninth Circuit has taken for itself, and the federal courts, effective oversight of at least the provider reimbursements portion of the Medicaid program, and in so doing, has subjected the States to inconsistent and atextual requirements, with the consequence of hundreds of millions of dollars in lost Medicaid efficiencies (and reductions in *other* Medicaid programs, such as optional services). This cannot be what Congress intended when it enacted the Medicaid Act, and more recently when it repealed the Boren Amendment in an effort to

underscore the need for State flexibility in administering Medicaid programs, without interference from private suits challenging the adequacy of provider reimbursements. *See Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 538-40 & n.15 (3d Cir. 2002); *Evergreen*, 235 F.3d at 919 n.12; *see also Sanchez v. Johnson*, 416 F.3d 1051, 1059-60 (9th Cir. 2005).

Finally, under the Ninth Circuit's ruling in *Dominguez*, these cases are no longer limited to challenges to state statutes that directly reduce Medicaid reimbursement rates to providers. Now, any state Medicaid reform effort may be enjoined on the theory that it may *potentially* impact provider payments. Thus, in *Dominguez*, SB6 was held preempted even though it did not reduce payments to IHSS providers, but merely changed a statutory cap according to which the State's contribution is calculated. The connection to Medicaid reimbursement rates is even more attenuated in *Putz v. Schwarzenegger*, a case filed in federal district court in California in January 2010: there, plaintiffs are invoking § 1396a(a)(30)(A) and the Supremacy Clause in an effort to challenge (and enjoin) a reduced appropriation to entities that provide purely administrative support in connection with the provision of IHSS services. *See* App., *infra*, 236. *But see National Ass'n of Chain Drug Stores v. Schwarzenegger*, No. CV 09-7097 CAS (MANx), ___ F. Supp. 2d ___, 2009 WL 5253371 (C.D. Cal. Dec. 22, 2009) (refusing to enter injunction where reduction in reimbursement rates to

pharmacies did not "result of any state law or policy mandating a change in reimbursement").

Petitioners believe that the earlier-filed *Independent Living* petition is a suitable vehicle for reaching the overarching issue of whether a state statute reducing Medicaid rates may be preempted based on judicially created funding criteria that lack any textual support whatsoever. The *Independent Living* decisions developed most of the framework for the Ninth Circuit's current analysis. However, if the Court would prefer to reach the issue with respect to reductions that are still in effect, or to reach the full panoply of requirements that the Ninth Circuit has now imposed, it should grant the present petition instead (and hold the *Independent Living* petition pending the disposition of this case).

## CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Dated: March 23, 2010

Respectfully submitted,

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**FOR PUBLICATION**

**UNITED STATES COURT OF APPEALS**
**FOR THE NINTH CIRCUIT**

CALIFORNIA PHARMACISTS ASSOCIATION; CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA DENTAL ASSOCIATION; CALIFORNIA HOSPITAL ASSOCIATION; CALIFORNIA ASSOCIATION FOR ADULT DAY SERVICES; MARIN APOTHECARY, INC., DBA Ross Valley Pharmacy; SOUTH SACRAMENTO PHARMACY; FARMACIA REMEDIOS, INC.; ACACIA ADULT DAY SERVICES; SHARP MEMORIAL HOSPITAL; GROSSMONT HOSPITAL CORPORATION; SHARP CHULA VISTA MEDICAL CENTER; SHARP CORONADO HOSPITAL AND HEALTHCARE CENTER; FEY GARCIA; CHARLES GALLAGHER,

*Plaintiffs-Appellees*,

v.

DAVID MAXWELL-JOLLY, Director of The California Department of Health Care Services,

*Defendant-Appellant*.

No. 09-55532

D.C. No. 2:09-cv-00722-CAS-MAN

OPINION

Appeal from the United States District Court
for the Central District of California
Christina A. Snyder, District Judge, Presiding

Argued and Submitted
January 19, 2010 – Pasadena, California

Filed March 3, 2010

Before: Stephen Reinhardt, William A. Fletcher and Milan D. Smith, Circuit Judges.

Opinion by Judge Milan D. Smith, Jr.

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## OPINION

MILAN D. SMITH, JR., Circuit Judge:

We are once again asked to consider whether the California Department of Health Care Services (Department) Director, David Maxwell-Jolly (Director), should be enjoined from implementing state legislation reducing payments to certain medical service providers. In this latest set of appeals, Plaintiffs-Appellees (California Pharmacists), a group of adult

day health care centers (ADHCs), hospitals, pharmacies, and beneficiaries of the State's Medicaid program, Medi-Cal, challenge a five percent reduction in those payments.[1] We affirm, and hold that the district court did not abuse its discretion in granting California Pharmacists's motion for a preliminary injunction because the State failed to "stud[y] the impact of the [five] percent rate reduction on the statutory factors of efficiency, economy, quality, and access to care" prior to implementing the rate reductions. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 652 (9th Cir. 2009) (*Independent Living II*).

## FACTUAL AND PROCEDURAL BACKGROUND

### I. Medicaid and Medi-Cal

Under Title XIX of the Social Security Act (the Medicaid Act), 42 U.S.C. § 1396 *et seq.*, the federal government provides funds to participating states to "enabl[e] each State, as far as practicable . . . to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical

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[1] Here we deal only with providers and beneficiaries of ADHCs. Mirroring the analysis of today's holdings, we address the challenges to AB 1183 with respect to pharmacy and hospital providers, as well as their beneficiaries, in two separate, concurrently filed memorandum dispositions.

services." 42 U.S.C. § 1396-1. "Medicaid is a cooperative federal-state program that directs federal funding to states to assist them in providing medical assistance to low-income individuals." *Katie A. ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1153-54 (9th Cir. 2007). As we have stated many times, it is the states that choose whether to participate in Medicaid. Should a state choose to participate in the Medicaid program, it must comply with federal Medicaid law. *Id.* California has chosen to participate in the program.

To receive federal funds, states must administer their programs in compliance with individual "State plans for medical assistance," which require approval by the federal Secretary of Health and Human Services. 42 U.S.C. § 1396-1. The State plan must "[s]pecify a single State agency established or designated to administer or supervise the administration of the plan." 42 C.F.R. § 431.10. The Defendant-Appellee's agency, the Department, "is the state agency responsible for the administration of California's version of Medicaid, the Medi-Cal program." *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1493 (9th Cir. 1997) (*Orthopaedic II*).

The Medicaid Act provides detailed requirements for state plans. *See* 42 U.S.C. § 1396a(a)(1)-(73). One of those provisions is § 1396a(a)(30)(A) (hereafter § 30(A)), the provision at issue in this appeal. Under § 30(A), a state plan must:

> provide such methods and procedures relating to . . . the payment for . . . care and services . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

*Id.* § 1396a(a)(30)(A). Thus, a state plan must establish health care provider reimbursement rates that are, among other things: (1) "consistent with high-quality medical care" (quality of care); and (2) "sufficient to enlist enough providers to ensure that medical services are generally available to Medicaid recipients" (access to care). *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1053 (9th Cir. 2008) (*Independent Living I*).

## II. Assembly Bill 5

On February 16, 2008, the California legislature enacted Assembly Bill X3 5 (AB 5) in special session. *See* 2008 Cal. Legis. Serv. 3rd Ex. Sess. Ch. 3. AB 5 reduced by ten percent payments under the Medi-Cal fee-for-service program for physicians, dentists, pharmacies, ADHCs, clinics, health systems, and other providers for services provided on or after July 1, 2008. Cal. Welf. & Inst. Code § 14105.19(b)(1). Section 14105.19 of the California Welfare & Institutions Code also reduced payments to managed health care

plans by the actuarial equivalent of the ten percent payment reduction. *Id.* § 14105.19(b)(3). Finally, AB 5 reduced payments to acute care hospitals not under contract with the Department for inpatient services. *Id.* § 14166.245(c). Under AB 5, these cuts were scheduled to take effect on July 1, 2008.

In *Independent Living II*, a group of pharmacies, health care providers, senior citizens' groups, and Medi-Cal beneficiaries brought an action under the Supremacy Clause, alleging that AB 5 conflicted with the requirements of § 30(A). We agreed, and held that under *Orthopaedic II* § 30(A) requires the Director to set provider reimbursement rates that "'bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs.'" *Indep. Living II*, 572 F.3d at 651 (quoting *Orthopaedic II*, 103 F.3d at 1496). We explained that *Orthopaedic II* interpreted § 30(A) to require the Director to "'rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.'" *Id.* at 652 (quoting *Orthopaedic II*, 103 F.3d at 1496). However, prior to enacting AB 5,

> [t]he Director failed to provide any evidence that the Department or the legislature studied the impact of the ten percent rate reduction on the statutory factors of efficiency, economy, quality, and access to care . . . , nor did [the Director] demonstrate that the

> Department considered reliable cost studies when adjusting its reimbursement rates.

*Id.*

## III. Assembly Bill 1183

On September 16, 2008, the California legislature passed Assembly Bill 1183 (AB 1183), which became effective on September 30, 2008. *See* Cal. Legis. Serv. Ch. 758. AB 1183 amended § 14105.19(b)(1) to provide that the ten percent rate reductions previously called for in AB 5 would end on February 28, 2009. *Id.* AB 1183 also added § 14105.191 and amended § 14166.245 of the California Welfare & Institutions Code, for either one percent, five percent, or ten percent rate reductions, depending on provider type. *See* Cal. Welf. & Inst. Code §§ 14105.191, 14166.245.

On January 29, 2009, California Pharmacists challenged the AB 1183 Medi-Cal reimbursement rate reductions. California Pharmacists sought to enjoin the Director from implementing AB 1183's five percent reduction in payments to ADHCs. ADHCs provide an alternative to institutional care, responding to the State's need "to establish and to continue a community-based system of quality adult day health care which will enable elderly persons or adults with disabilities to maintain maximum independence." Cal. Health & Safety Code § 1570.2. Though recognizing the need for custodial care, the California legislature has concluded that "overreliance on [custodial]

care has proven to be a costly panacea in both financial and human terms, often traumatic, and destructive of continuing family relationships and the capacity for independent living." *Id.*

The district court granted the preliminary injunction. It held that California Pharmacists had demonstrated a likelihood of success on the merits for three reasons. First, the legislative history showed no indication that the legislature considered § 30(A) prior to passage of AB 1183. Second, since the Department was given no discretion to alter the rate reductions imposed by the legislature, any analysis that the Department completed in February 2009, and thus after the reductions were enacted, did not satisfy the requirements of *Orthopaedic II*. And third, any analysis conducted by the Department was inadequate because the Department relied on costs incurred at intermediate care facilities (NF-As), which the district court considered to be an inadequate proxy for ADHC costs. The district court also held that California Pharmacists had demonstrated a risk of irreparable harm and that the balance of equities and public interest weighed in favor of injunctive relief. The Director timely appealed.

The Director raises three issues on appeal. First, the Director argues that the district court erred in holding that the legislature itself was required to conduct cost studies or analyses prior to enactment of AB 1183 to determine whether the proposed rate reductions complied with the efficiency, economy, and quality of care provisions of § 30(A). Second, the

Director contends that even if the legislature was required to conduct the relevant analysis, the district court committed clear error in concluding that the legislature did not adequately consider the § 30(A) factors prior to enacting AB 1183. Third, the Director argues that the district court erred in concluding that California Pharmacists had met their burden of demonstrating irreparable harm with respect to reduced reimbursement rates under AB 1183.

## JURISDICTION AND STANDARD OF REVIEW

We have jurisdiction over this appeal pursuant to 28 U.S.C. § 1292(a)(1). A district court's decision to grant or deny a preliminary injunction is reviewed for abuse of discretion. *Indep. Living II*, 572 F.3d at 651. We recently restated our two-part test used to determine whether a district court has abused its discretion. First, we "determine de novo whether the trial court identified the correct legal rule to apply to the relief requested." *United States v. Hinkson*, 585 F.3d 1247, 1262 (9th Cir. 2009) (en banc). If the trial court did not identify the correct legal rule, it abused its discretion. *Id.* at 1262. Second, we must determine if the district court's "application of the correct legal standard was (1) 'illogical,' (2) 'implausible,' or (3) without 'support in inferences that may be drawn from the facts in the record.'" *Id.* (quoting *Anderson v. City of Bessemer City*, 470 U.S. 564, 577 (1985)).

In granting a request for a preliminary injunction, a district court abuses its discretion if it "base[s]

its decision on an erroneous legal standard or clearly erroneous findings of fact." *Earth Island Inst. v. U.S. Forest Serv.*, 442 F.3d 1147, 1156 (9th Cir. 2006), *abrogated on other grounds by Winter v. Natural Res. Def. Council, Inc.*, 129 S. Ct. 365 (2008). We review conclusions of law de novo and findings of fact for clear error. *Id.* Under this standard, "[a]s long as the district court got the law right, it will not be reversed simply because the appellate court would have arrived at a different result if it had applied the law to the facts of the case." *Id.* (internal quotation marks omitted).

## DISCUSSION

In seeking a preliminary injunction in a case in which the public interest is involved, a plaintiff must overcome four hurdles. Thus, California Pharmacists must show that: (1) they are likely to succeed on the merits; (2) they are likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in their favor; and (4) an injunction is in the public interest. *Cal. Pharms. Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 849 (9th Cir. 2009) (citing *Winter*, 129 S. Ct. at 376); *see also Am. Trucking Ass'ns, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1052 (9th Cir. 2009).

### I. Likelihood of Success on the Merits

In *Orthopaedic II*, we held that § 30(A) requires

> the Director [to] set hospital outpatient reimbursement rates that bear a reasonable

> relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

103 F.3d at 1496.

We address the Director's arguments in turn.

### A. The Body Responsible for Complying with § 30(A)

First, the Director argues that *Orthopaedic II* did not hold that rate setting must be based upon pre-enactment legislative studies undertaken and completed by the legislature itself prior to legislative action authorizing a state department to implement rate reductions. According to the Director, at issue in *Orthopaedic II* were statutorily mandated rate changes not unlike those set pursuant to AB 1183. However, despite those enactments, we focused solely on the Department's actions, rather than on the legislature's, and thus only the Department is required to consider the § 30(A) factors. We disagree.

In *Orthopaedic II*, *none* of the disputed rate-settings was actually *set* by the legislature. *See Orthopaedic Hosp. v. Kizer*, No. 90-4209, 1992 WL 345652 (C.D. Cal. Oct. 5, 1992) (*Orthopaedic I*). To the contrary, the legislative enactments granted the

Director broad discretion to set the applicable rates in the face of general governing criteria. *See, e.g., Orthopaedic I,* 1992 WL 345652, at *7 (describing that reimbursement rates for rural hospitals were to "be set at a level which will provide incentives for rural hospitals to focus on the provision of outpatient services and . . . reduce the financial losses incurred by the facilities"); *id.* at *8 (describing that for delivery services rates the Department "shall eliminate the Medi-Cal reimbursement differential for obstetrical services" by equalizing reimbursement for Caesarean and non-Cesarean section deliveries); *id.* at *9 (statute required the Department to amend the method for reimbursing disproportionate share hospitals for outpatient services, to which the "Department responded by developing a new payment methodology"). Since the Director set the challenged rates, *Orthopaedic II* addressed whether the Medicaid Act "requires the *Department* to consider the costs hospitals incur in delivering services *when setting* specific payment rates under [§ 30(A)]." 103 F.3d at 1496 (emphases added). Looking to the clear language in the statute, we noted that § 30(A) "provides that *payments* for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Id.* We reasoned that costs were an integral factor to be considered in the payment calculus, since "[t]he Department cannot know *that it is setting rates* that are consistent with [§ 30(A)'s relevant factors] without considering the costs of providing such services." *Id.* (emphasis

added). Thus, we held that "*payments* for hospital outpatient services must bear a reasonable relationship to the costs of providing quality of care incurred by efficiently and economically operated hospitals." *Id.*

Unlike the statutes at issue in *Orthopaedic II*, the State has taken a different approach to setting rates under AB 1183. Under AB 1183, the legislature mandated that the Director reduce provider payments by a fixed percentage. *See, e.g.*, Cal. Welf. & Inst. Code § 14105.191(b)(2) ("[P]ayments to the following classes of providers shall be reduced by 5 percent for Medi-Cal fee-for-service benefits[.]"). Thus, the Director is misguided in arguing that our focus on the Department in *Orthopaedic II* absolves the legislature of the same requirements when it sets rates. In other words, in *Orthopaedic II*, there was no question that the Department set reimbursement rates. Those rates provided payments for the medical service at issue under the State's plan – there, hospital outpatient services. We had no reason to focus on what the State legislature considered before rates were set since the legislature was one step removed from the regulations promulgated by the Department. As noted, the legislature merely outlined broad goals for the Department, a process separate and distinct from determining the *effect* of a specific rate reduction on the statutory factors of efficiency, economy, quality, and access to care. Yet if the legislature elects to bypass the Department, and set rates itself, it must

engage in the same principled analysis we required of the Director in *Orthopaedic II*.

Moreover, in *Orthopaedic I*, the Director made the inverse of the argument he asserts here. There, he argued that in enacting the governing statutes, the legislature considered the relevant § 30(A) factors, thus excusing the Department's need to do the same when it set rates based on the legislature's commands. *See Orthopaedic I*, 1992 WL 345652, at *7-11. The district court rejected this argument, holding first that the statutes did not "purport to establish any specific payment rates," *id.* at 7, and second that even if the legislature had considered the relevant factors, that did not "relieve the Department of the obligation to further consider [the relevant factors] in exercising what discretion it had in implementing the legislature's general mandate," *id.* at 9. In addition, the court noted, "nor is there adequate evidence in the record demonstrating that the *state legislature* at any time considered [the relevant factors] in connection with the equalization of rates." *Id.* The district court explained:

> In sum, *if* there was evidence *both* that (1) in setting the challenging rates, the Department had merely in rote fashion been implementing a precisely-crafted statutory enactment that did not permit the Department to exercise any significant discretion whatsoever, and further, that (2) the legislature in enacting the statute had expressly considered "efficiency, economy, and quality of care," the Court might agree that the

> Department need not have considered "efficiency, economy, and quality of care," at all. But there is convincing evidence of neither.

*Id.* Thus, we are not telling the State something new.

Indeed, we find no distinction between the method by which rates were set under either AB 1183 or AB 5. Under AB 5, the California legislature enacted a statutorily mandated across-the-board rate reduction. In holding that the Director violated § 30(A) when he implemented AB 5's rate reductions, we held "[t]he Director failed to provide any evidence that the Department *or the legislature* studied the impact of the ten percent rate reduction on the statutory factors . . . *prior to enacting* AB 5." *Indep. Living II*, 572 F.3d at 652 (emphases added). We noted several times our concern with the context in which the *legislation* was passed, and focused on what State officials failed to consider prior to enactment. *See id.* at 655-56 (holding that the State's decision to pass legislation reducing Medi-Cal reimbursement rates for purely budgetary concerns violated federal law); *id.* at 656 (concluding that the State's Legislative Analyst was the only "State official" to have "considered – let alone studied" the impact of the rate reduction on services provided to Medi-Cal beneficiaries); *id.* at n.12 ("Nothing in the record connects the decision to cut Medi-Cal reimbursement rates by ten percent across-the-board to a factfinding process initiated by state officials."). Such an approach is consistent with that of our sister circuits, where in the context of legislative, as opposed to agency, rate-setting, they too have

focused on ensuring that the legislative body had information before it so that it could properly consider efficiency, economy, quality of care, and access to services *before* enacting rates. *See Minn. Homecare Ass'n, Inc. v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (holding that although the agency did not provide any formal § 30(A) analysis to the legislature, lobbyists "actively participated in the . . . legislative session" such that the legislature adequately considered § 30(A) when it raised reimbursement rates); *cf. Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) (refusing to consider evidence offered during agency hearings regarding the effect of rate cuts on accessibility because it "could only be confirmed by historical data accumulated after the cuts were made").[3]

In sum, we find nothing remarkable in holding that the final body responsible for setting Medicaid reimbursement rates must study the impact of the contemplated rate reduction on the statutory factors of efficiency, economy, quality of care, and access to

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[3] The Director's reliance on *Folden v. Wash. State Dep't of Soc. & Health Servs.*, 981 F.2d 1054 (9th Cir. 1992), is also misplaced. In *Folden*, the owners of fourteen nursing home care facilities challenged Washington state Medicaid payments under a now repealed section of the Medicaid Act known as the Boren Amendment. 981 F.2d at 1056. We have numerous times rejected the Director's attempt to "graft past judicial interpretation of the Boren Amendment onto this court's interpretation of § 30(A)." *Indep. Living II*, 572 F.3d at 654-56 & nn.11-12; *Alaska Dep't of Health and Soc. Servs. v. Ctrs. for Medicare and Medicaid Servs.*, 424 F.3d 931, 940-41 (9th Cir. 2005).

care *prior to* setting or adjusting payment rates. We emphasize that the State need not follow "any prescribed method of analyzing and considering [the § 30(A)] factors." *Minn. Homecare Ass'n*, 108 F.3d at 918; *Orthopaedic II*, 103 F.3d at 1498 (refusing to impose a "rigid formula" for the Department to follow). But as we stated in *Orthopaedic II*, "Congress intended payments to be flexible within a range; payments should be no higher than what is required to provide efficient and economical care, but still high enough to provide for quality care and to ensure access to services." 103 F.3d at 1497. The only way to ensure that Congress's intent is realized is for the State to study the impact of the contemplated rate change on the statutory factors *prior to* setting rates. Thus, in no way do we mean to suggest that the State is proscribed from setting or adjusting reimbursement rates. We simply reaffirm that if it does so, it must comply with federal law.

### B. Legislative Consideration Prior to Setting Rates

Having determined that the State legislature was required to study the impact of the five percent rate reduction on the statutory factors of efficiency, economy, quality, and access to care prior to enacting AB 1183, we next consider whether it did so. The Director argues that even though the legislature was not required to do so, the district court committed clear error in concluding that the legislature did not

adequately consider the § 30(A) factors prior to implementing AB 1183.

In support of his argument, the Director submits the declaration of the Department's Deputy Director for Legislative and Governmental Affairs. The Deputy Director states that in May 2008, the Senate and Assembly proposals were released in public hearings held by the Senate and Assembly Budget Committees. According to the Deputy Director, Department employees "provid[ed] information, technical assistance, and responses to numerous inquiries to legislative staff members concerning the various 5% and 1% rate reductions that were included in AB 1183." The Director also references the May 30, 2008, agenda released by the Assembly Budget Subcommitee No. 1 on Health and Human Services. That agenda lists certain "items to be heard" including proposed actions to "Maintain Essential Health Care Services and Eligibility," such as "Restore 10% provider rate cut for physicians and other healthcare providers" and "Partially restore long-term care rate reductions enacted in AB 5 X 3 (reduce cut from 10% to 5%)." The only proposed action that includes a discussion relevant to ADHCs explains that individuals with developmental disabilities living in Intermediate Care Facilities are eligible for ADHC services, and that such clarification in a trailer bill is necessary so that the State's Department of Developmental Services will no longer have to "fund these ADHC services at 100 percent General Fund cost."

Next, the Director points to the California Senate Committee on Budget and Fiscal Review for May 30, 2008, which includes recommendations for modification of several rate reductions or elimination of services. With respect to ADHC services, one entry contains the same description of the proposed trailer bill needed to clarify that individuals with developmental disabilities in Intermediate Care Facilities are eligible for participation in the ADHC Program. The other entry relevant to ADHCs is a brief explanation of the Department's request for an increase in funds for ADHC services due to an increase in enrollees.

The Director also points to the June 11, 2008, Subcommittee 3 Health, Human Services, Labor, and Veterans Affairs Major Action Report. That Report notes certain of the Department's "Highlights for the Medi-Cal Program." The Deputy Director calls particular attention to the entry that indicates that the 2008-09 budget bill "Provided a partial restoration to the rates reimbursed under Medi-Cal by providing a 5 percent across-the-board restoration to the 10 percent reduction as proposed by the Governor and taken in Special Session through [AB 5]. In the Medi-Cal Program, this resulted in an increase of about $597 million ($302 million General Fund)." The Report also noted adoption of the ADHC proposals set forth above.

The Director further points to the Budget Conference Committee 2008 Action List dated July 9, 2008, which shows seven items that the Assembly

and Senate voted on, ultimately contained in AB 1183, such as "Partial Restoration of Medi-Cal Fee-For-Service Provider Payments" and "Partial Restoration of Medi-Cal Pharmacy Rate." The Director argues that this Action List illustrates "that the Assembly and Senate voted on the very Medi-Cal rate reduction language that was ultimately contained in AB 1183." The July 2008 Summary Overview Budget Conference Committee Report summarizes many of the rate reductions enacted as part of AB 1183. Finally, the Director refers to the State's Legislative Analyst Office's analysis of the 2008-09 Budget, which includes recommendations from the State's Legislative Analyst concerning the Governor's proposed reductions to provider reimbursement.

The district court explicitly mentioned the legislative history described above (with the exception of the Legislative Analyst Office's analysis), and determined that it does not show that there was consideration of the § 30(A) factors. We agree, since the legislative history nowhere mentions any of the § 30(A) factors, *see Orthopaedic I*, 1992 WL 345652, at *8 ("Tellingly – although not dispositively *the terms 'efficiency,' 'economy,' and 'equality* [sic] *of care' appear nowhere in these documents.*"), and is concerned solely with budgetary matters, *see Indep. Living II*, 572 F.3d at 659 ("State budgetary concerns cannot . . . be the conclusive factor in decisions regarding Medicaid." (internal quotation marks omitted)). Indeed, the legislative history contains no indication that, in adjusting rates under AB 1183, the State "'rel[ied] on

responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.'" *Id.* at 652 (quoting *Orthopaedic II*, 103 F.3d at 1496). The Legislative Analyst Office's analysis of the 2008-09 Budget appears to be the very same report we referenced in *Independent Living II*. *See id.* at 656. It discusses the Governor's proposal of a *ten percent* provider rate reduction, which the State's own Legislative Analyst recommended rejecting for all providers except hospitals because those rate reductions had "the potential to negatively impact the operation of the Medi-Cal Program and the services provided to beneficiaries by limiting access to providers and services." It is hardly clear error for the district court to have failed to mention a report conducted without regard to the specific rate reductions before it. Accordingly, we will not disrupt the district court's factual findings, as they are not clearly erroneous.

### C. The Department's Analysis

The Director also argues that the district court erred in failing to consider the analysis conducted by the Department, completed after the law's enactment. In rejecting the Department's analysis, the district court held that AB 1183 did not provide the Department with any discretion, citing Cal. Welf. & Inst. Code § 14105.191(a), which provides that "[n]otwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director *shall* reduce provider payments." (emphasis added). The district court reasoned

that since the Department was not given any authority to alter the rate reduction imposed by the legislature, the Department's *post hoc* analysis does not satisfy the requirements of *Orthopaedic II*. The district court went on to hold that even if a *post hoc* analysis was sufficient, the Department relied on an inadequate proxy for ADHC costs when it considered data for NF-As.

To satisfy § 30(A), any analysis of reimbursement rates on the statutory factors of efficiency, economy, quality, and access to care, must have the potential to influence the rate-setting process. *See Indep. Living II*, 572 F.3d at 652 n.9 (holding that the district court did not abuse its discretion in concluding that *post hoc* rationalizations of the disputed reimbursement rates do not satisfy the procedural requirements of *Orthopaedic II*); *see also Orthopaedic II*, 103 F.3d at 1499 ("[T]he Department must consider hospitals' costs *based on* reliable information *when setting* reimbursement rates. . . ." (emphases added)); *Ark. Med. Soc'y*, 6 F.3d at 530. Yet the Department's analysis of AB 1183 with respect to ADHCs was issued on February 24, 2009, more than five months *after* the legislature enacted AB 1183, but prior to the cuts' implementation. Therefore, for the Department's analysis to have the requisite potential effect, the Director would have to have discretion regarding implementation of the rates.

In his reply brief, and for the first time in this litigation, the Director argues that the Department's post-enactment study is sufficient because the

Department retained discretion under AB 1183 not to *implement* the reductions before March 1, 2009. Thus, the Director argues, the Department's February 24, 2009, analysis would still be meaningful because the Director had authority to affect rates by deciding not to implement them.[3] Although the Director has

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[3] The Director's argument that he has discretion regarding the rates is drawn from a footnote in the district court's analysis in *Orthopaedic I*. There, the Director argued that legislative consideration of the § 30(A) factors excused the Department from again having to consider § 30(A). In rejecting that argument, the district court noted that the relevant statutory enactments "gave the Department fairly wide discretion in implementing the basic changes outlined in the statute." *Orthopaedic I*, 1992 WL 345652, at *9. To buttress that conclusion, the district court pointed out that under the Medicaid Act, the "ultimate responsibility" for administration of a state's Medicaid program is entrusted to a "single state agency." *Id.* at n.14 (quoting 42 C.F.R. § 431.10). As a result, the district court concluded that under federal law, the state agency has the "final say in what payment rates to set, *notwithstanding a legislature's efforts to provide broad guidelines for the agency.*" *Id.* (emphasis added). The court found it particularly relevant that the California legislature directed the Department to "seek federal approval for this section, if necessary." *Id.* (citing California Senate Bill 2563) (internal quotation marks omitted). The court also noted that subsection (a) under the Medi-Cal enabling statute grants the Department "extremely broad authority" to "comply with legislative budgetary enactments" only to the extent that those enactments comply with federal law. *Id.*

As we have described, there are a number of notable differences between the legislative enactments at issue in *Orthopaedic I* and AB 1183, thus raising the question of whether, under AB 1183, the Director had the "final say in what payment rates to set." *Id.* However, because we reject the Director's argument for the reasons set forth below, we do not decide whether differences between AB 1183 and the legislative enactments at

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clearly waived this argument by failing to raise it in his opening brief, *see Indep. Towers of Wash. v. Washington*, 350 F.3d 925, 929 (9th Cir. 2003), we nevertheless consider and reject the Director's argument on the merits.

The Director argues that if the Department determined that the reduced payments for any services would not comply with the relevant § 30(A) factors, the Department retained the discretion[4] not to implement those reductions. As a result, the legislature made implementation of the rate reductions dependent on whether the Department determined that they complied with federal law.[5]

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issue in *Orthopaedic I* are dispositive of the Director's discretion in this case.

[4] At oral argument the Director conceded that he did not have authority to change the rates set by the legislature, but, he argued, he could exercise a veto power based on a determination that the rates did not comply with the statutory factors in § 30(A). We need not decide whether the type of discretion contemplated by § 14105(a) of the California Welfare & Institutions Code is different from that under § 14105.191(i). That is, that the Director may "limit the rates," or "adopt regulations setting rates" under § 14105(a) would seem to provide for a different type of discretion than deciding simply not to implement the rates as set. However, because we hold that the Director did not retain any discretion to act once rates had been set, we do not discuss the distinction, if any, between the discretion contemplated by § 14105(a) as opposed to § 14105.191(i).

[5] We need not decide whether a study completed after rates have been set complies with § 30(A) where the Department has discretion not to implement the rates. For purposes of our analysis only, we assume such a study would suffice, but do not

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The Director relies on § 14105.191(i), which states:

> The department shall promptly seek any necessary federal approvals for the implementation of this section. To the extent that federal financial participation is not available with respect to any payment that is reduced or limited pursuant to this section, the director may elect not to implement that reduction or limitation.

Cal. Welf. & Inst. Code § 14105.191(i). The Director also points to the Medi-Cal enabling statute, Cal. Welf. & Inst. Code § 14105(a):

> The director shall prescribe the policies to be followed in the administration of this chapter, may limit the rates of payment for health care services, and shall adopt any rules and regulations as are necessary for carrying out, but are not inconsistent with, the provisions thereof.

Subsection (a) goes on to provide:

> In order to implement expeditiously the budgeting decisions of the Legislature, the director shall, to the extent permitted by federal law, adopt regulations setting rates that reflect these budgeting decisions within one month after the enactment of the Budget Act and of any other appropriation that

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so hold because we find that the Director did not retain any discretion in this case.

> changes the level of funding for Medi-Cal services.

Cal. Welf. & Inst. Code § 14105(a).

The Director's is not the most natural reading of the statute. Section 14105.191(i) does not clearly invest the Director with the discretion not to implement the legislature's rate reductions. Rather, it first directs the Department to "seek any necessary federal approvals" to implement the rate reductions. Cal. Welf. & Inst. Code § 14105.191(i). Only then does it permit the Director not to implement any reduction "[t]o the extent that federal financial participation *is not available.*" *Id.* (emphasis added). Thus, the most natural reading would seem to be one of budgetary concern; if federal money is not available for any particular payment reduction, the Director may choose to save the State money by not implementing the reduction. Such a reading comports with the budgetary nature of AB 1183's legislative history. *See Ariz. State Bd. For Charter Sch. v. U.S. Dep't of Educ.*, 464 F.3d 1003, 1008 (9th Cir. 2006) ("When a natural reading of the statute[ ] leads to a rational, commonsense result, an alteration of meaning is not only unnecessary, but also extrajudicial.").

The Director asks that we read into the statutory text a process by which the Department could first analyze the impact of the five percent payment reduction on the § 30(A) factors and then elect to implement the reduction based on that analysis. However, regardless of whether any such process was

contemplated in the statute, the record clearly demonstrates that no process of the kind the Director envisions took place. First, on September 30, 2008, the Department submitted its State Plan Amendment, incorporating AB 1183's rate reductions. In its State Plan Amendment, the Department stated that it had "determined that payments will continue to comply with any upper spending limits contained in Part 447 that were adopted to implement the 'efficiency, economy, and quality of care' provision of [§ 30(A)]. Beneficiaries will continue to have access to covered services as required by Part 447." Yet the Department did not issue a § 30(A) analysis until February 24, 2009 and produced nothing that would indicate that it studied the impact of AB 1183 on efficiency, economy, quality, and access to care prior to September 30, 2008. The State Plan Amendment also does not mention the Department's discretion not to implement the rate reductions based on federal participation.

In addition, on February 13, 2009, the State published notice in the California Regulatory Notice Register that "Section 14105.191 of the [Welfare and Institutions] Code is reducing the payments that would otherwise be paid for [adult day health care services] under the current rate methodology from 10 percent to 5 percent for dates of service on or after March 1, 2009. The State's Notice further provided that the Department

> is mandated by state law to implement the above change in reimbursement. [The

> Department] has considered the impact of this reimbursement on providers and Medi-Cal beneficiaries. [The Department's] assessment is that reimbursement will continue to compensate a high percentage of costs incurred for these facility services and that Medi-Cal beneficiaries will continue to have access to these services consistent with [§ 30(A)].

As with the State Plan Amendment, the Notice predates any analysis issued by the Department, yet definitively announces payment reductions from ten to five percent. Moreover, the Notice states that the Department "is mandated" to implement the rates, further undermining the Director's reading of § 14105.191(i).

In sum, the Director's argument that he retained discretion not to implement AB 1183's rate reductions is not supported by the record. The Department's February 24 analysis issued well after decisions had been made to reduce payments by five percent, and nothing in the record indicates that the Department retained the discretion not to implement the rate reductions based on a § 30(A) analysis. To comply with § 30(A), the State must study the impact of the contemplated rate reduction on the statutory factors of efficiency, economy, quality, and access to care prior to legislative enactment or in a manner that allows meaningful consideration of such input prior to implementation. Here, the State did neither.

In addition, regardless of whether the Director retained the discretion to act in the manner he posits, we agree with the district court that the Department's analysis was insufficient. Reviewing for clear error, we hold that the district court did not abuse its discretion in finding that the Department's reliance on NF-A rather than ADHC data was inadequate. The Department looked to the average costs of only six NF-A facilities, with widely varied costs, as a proxy for the 313 ADHCs in the Medi-Cal program. In its ADHC analysis, completed in February 2009, the Department explained that it had "just begun the process of auditing the costs of ADHCs for purposes of establishing rates under the new costs based methodology that is scheduled to go into effect on August 1, 2010[,]" and therefore, "in order to assess how ADHC reimbursement compares to the costs that may be incurred by an ADHC in providing ADHC services to Medi-Cal recipients," it used as a proxy how Medi-Cal reimbursement compares to NF-A costs. The Director concedes that a prospective cost reimbursement methodology for ADHCs is "still more than one year away." In the meantime, nothing in the record indicates that the district court clearly erred in concluding that the Department's use of NF-A costs was an inadequate proxy for ADHC costs. *Cf. Orthopaedic II*, 103 F.3d at 1500 (holding that the Department violated § 30(A) when readopting reimbursement rates for *hospitals* 'costs by not considering *hospitals*' costs when reevaluating its rates). Accordingly, it was not an abuse of discretion for the district court to have rejected the Department's analysis.

## II. Irreparable Harm

The Director also argues that the district court erred in holding that California Pharmacists demonstrated a likelihood of irreparable harm. After reviewing the evidence, the district court held that "the evidence submitted by plaintiffs indicate[s] that Medi-Cal beneficiaries are at risk of losing access to ADHC services due to the AB 1183 rate reduction." The Director argues that in determining whether California Pharmacists have shown a likelihood of irreparable harm, the district court was required to compare Medi-Cal beneficiaries' access to ADHC services to that of the general population's.

Once again, under § 30(A), each state's Medicaid plan must be

> sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A). This is referred to as the "equal access to care provision," *Orthopaedic II*, 103 F.3d at 1498, and requires that a state plan establish reimbursement rates sufficient to enlist enough providers to ensure that medical services are generally available to Medicaid recipients, *id.* at 1497. The Director argues that the district court erred in failing to apply the equal access to care provision in the context of plaintiffs' claims of irreparable injury. In other words, the Director argues that there can be no

finding of irreparable harm where "care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." § 30(A). According to the Director, applying this standard here, the evidence before the district court established that ADHC services are not generally available to the general population and thus California Pharmacists made no showing of irreparable injury.

In *Independent Living II*, we discussed the distinction between § 30(A)'s procedural and substantive requirements. We considered the "potential difficulties inherent in assessing substantive compliance with the factors laid out in § 30(A)," which made more attractive, by comparison, the "process-oriented view of the statute espoused in *Orthopaedic* [*II*]." *Indep. Living II*, 572 F.3d at 657. While explaining that there is a difference between substantive and procedural compliance with § 30(A), *id.* at 656, we also explained their interdependence, since "it is fair to assume that a rate that is set arbitrarily, without reference to the Section 30(A) requirements, is unlikely to meet the equal access and quality requirements," *id.* at 657 (internal quotation marks omitted). We reaffirmed *Orthopaedic II*'s requirement that states comply with the procedural components of § 30(A) by setting provider reimbursement rates only after consideration of the relevant statutory factors of efficiency, economy, quality, and access to care. *Id.*

The Director's approach to the irreparable harm analysis conflates § 30(A)'s procedural and substantive

requirements. We do not require plaintiffs to show the State has committed a substantive violation of § 30(A)'s access provision when they can show that the State did not comply with § 30(A)'s procedural components. In other words, showing a procedural violation of the statute – that is, the State's failure to consider the impact of the contemplated rate on the statutory factors set forth in § 30(A) – may demonstrate a likelihood of success on the merits that the setting of provider reimbursement rates conflicts with § 30(A). Determining whether plaintiffs have made a sufficient showing of irreparable harm is a separate inquiry, which does not turn on the State's substantive compliance with § 30(A). Rather, to show a risk of irreparable harm, plaintiffs may show either, as Medicaid beneficiaries, "that enforcement of a proposed rule 'may deny them needed medical care[,]' " *Indep. Living II*, 572 F.3d at 658 (quoting *Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982)), or, as Medicaid providers, that they will lose considerable revenue through the reduction in payments that they will be unable to recover due to the State's Eleventh Amendment sovereign immunity, *Cal. Pharms. Ass'n*, 563 F.3d at 850-52.

Requiring a substantive violation of the equal access to care provision in order to meet the irreparable injury prong would also run afoul of our Supremacy Clause jurisprudence. In *California Pharmacists*, we held that in an action brought under the Supremacy Clause, a finding of irreparable harm does not turn on "whether the plaintiffs asserting the economic

injury were in any sense intended beneficiaries of the federal statute on which the Supremacy Clause cause of action was premised." *Id.* at 851. Because "[a] cause of action based on the Supremacy Clause obviates the need for reliance on third-party rights," private parties bringing a Supremacy Clause cause of action can "enforce the structural relationship between the federal and state governments so long as they ha[ve] Article III standing as, essentially, private enforcers of the Supremacy Clause." *Id.* Thus, as stated above, plaintiffs need only show harm to Medi-Cal service providers or their members in order to obtain injunctive relief. *Id.* at 850. The Director's more narrow approach would allow injunctive relief only where plaintiffs are able to show that Medi-Cal *beneficiaries* have worse access to care and services than that available to the general population.

Finally, we have stated that even if § 30(A) imposes a substantive requirement, a rate reduction might still conflict with the statute if *at least some* providers stop treating Medi-Cal beneficiaries. *Indep. Living II*, 572 F.3d at 656-57. The Director concedes that here, the evidence indicates that at least some ADHC Medi-Cal providers would stop treating beneficiaries due to AB 1183. Thus, even if we were to require a substantive violation of the statute to support a finding of irreparable harm, we would find that violation here.

Therefore, we reject the Director's argument that there can be no finding of irreparable harm unless the plaintiffs show a substantive violation of § 30(A)'s

access to care provision. The Director makes no serious attempt to dispute the district court's factual finding that, in light of the evidence, "Medi-Cal beneficiaries are at risk of losing access to ADHC services due to the AB 1183 rate reduction." Upon our review of the evidence, we do not find the district court's conclusion to be clearly erroneous. Accordingly, the district court did not abuse its discretion in finding that California Pharmacists established sufficient irreparable harm to warrant a preliminary injunction.

## III. Balance of Equities and the Public Interest

Finally, the Director argues that because of the State's deepening fiscal crisis, a preliminary injunction should not issue. The Director insists that the legislature be allowed to exercise "its considered judgment" in a manner that serves the best interests of both Medi-Cal recipients and the State as a whole, and that injunctions against payment reductions have forced the State to eliminate many optional Medi-Cal services. The district court recognized the State's interest in meeting its financial obligations but held that the State's financial woes were outweighed by the public's interest in access to health care, particularly because "nothing . . . prevents [the State] from imposing a rate reduction after . . . appropriately consider[ing] and appl[ying] the relevant factors."

"The public interest analysis for the issuance of a preliminary injunction requires us to consider

'whether there exists some critical public interest that would be injured by the grant of preliminary relief.'" *Indep. Living II*, 572 F.3d at 659 (quoting *Hybritech Inc. v. Abbott Labs.*, 849 F.2d 1446, 1458 (Fed. Cir. 1988)). We have held that "there is a robust public interest in safeguarding access to health care for those eligible for Medicaid, whom Congress has recognized as 'the most needy in the country.'" *Id.* (quoting *Schweiker v. Hogan*, 457 U.S. 569, 590 (1982)). We continue to recognize this important public interest in the context of social welfare cases. As the district court stated, the State is free to exercise its "considered judgment" and reduce Medi-Cal reimbursement rates. Yet it may not do so for purely budgetary reasons, *Ark. Med. Soc'y*, 6 F.3d at 531, nor may it do so in a manner that violates federal law, *Indep. Living II*, 572 F.3d at 659. Accordingly, we hold that the district court did not abuse its discretion in concluding that the balance of hardships and the public interest weighed in favor of enjoining implementation of the five percent rate reduction required by AB 1183.

## CONCLUSION

We have now handed down multiple decisions instructing the State on § 30(A)'s procedural requirements. We trust that the State now understands that in order for it to comply with § 30(A)'s "requirement that payments for services must be consistent with efficiency, economy, and quality of care, and sufficient to ensure access," *Orthopaedic II*, 103 F.3d at 1500, it

must: (1) "rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting," *id.* at 1496; *and* (2) study the impact of the contemplated rate change(s) on the statutory factors *prior to* setting rates, or in a manner that allows those studies to have a meaningful impact on rates before they are finalized. Because the State did neither with respect to AB 1183, we affirm the district court's order granting California Pharmacists's motion for a preliminary injunction.

**AFFIRMED.**

**NOT FOR PUBLICATION**

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

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| CALIFORNIA PHARMACISTS ASSOCIATION; et al.,<br>Plaintiffs,<br>and<br>CALIFORNIA HOSPITAL ASSOCIATION; et al.,<br>Plaintiffs-Appellants,<br>v.<br>DAVID MAXWELL-JOLLY, Director of The California Department of Health Care Services,<br>Defendant-Appellee. | No. 09-55365<br>D.C. No. 2:09-cv-00722-CAS-MAN<br>MEMORANDUM*<br>(Filed Mar. 3, 2010) |

Appeal from the United States District Court
for the Central District of California
Christina A. Snyder, District Judge, Presiding

Argued and Submitted January 19, 2010
Pasadena, California

Before: REINHARDT, W. FLETCHER and M. SMITH, Circuit Judges.

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* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

Plaintiffs-Appellants California Hospital Association et al. sought a preliminary injunction in the district court to enjoin AB 1183's five percent Medi-Cal reimbursement rate reduction as to certain types of hospital services.[1] As the facts and procedural history are familiar to the parties, we do not recite them here except as necessary to explain our decision. We reverse the district court's denial of a preliminary injunction.

While the district court held that Plaintiffs had shown a likelihood of success on the merits, it held that the evidence submitted by Plaintiffs did not demonstrate that "Medi-Cal *beneficiaries* will go without access to needed inpatient and outpatient services under the AB 1183 rate reductions." (emphasis addded [sic]).

The district court abused its discretion in light of our holding in *California Pharmacists Association v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009) (*California Pharmacists I*). *In California Pharmacists I*, we held that in an action brought under the Supremacy Clause, a finding of irreparable harm does not turn on "whether the plaintiffs asserting the

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[1] AB 1183's reimbursement rates vary depending on four types of hospital services: (1) inpatient services; (2) outpatient services; (3) Distinct Part Nursing Facilities; and (4) subacute services. With respect to inpatient services, this appeal concerns reimbursement for *non-contract* inpatient hospital services. Reimbursement rates for inpatient services at hospitals that have contracted with the State are unaffected by AB 1183.

economic injury were in any sense intended beneficiaries of the federal statute on which the Supremacy Clause cause of action was premised." 563 F.3d at 851. Because "[a] cause of action based on the Supremacy Clause obviates the need for reliance on third-party rights," Plaintiffs "could enforce the structural relationship between the federal and state governments so long as they had Article III standing as, essentially, private enforcers of the Supremacy Clause." *Id.* We went on to hold that the reduction in Medi-Cal revenue mandated by AB 1183 harmed Plaintiffs, *id.*, and that any such harm was irreparable because Plaintiffs could not recover money damages against the Department due to the State's Eleventh Amendment sovereign immunity, *id.* at 852.

We recently reaffirmed that holding. *Cal. Pharms. Ass'n v. Maxwell-Jolly*, No. 09-55532, slip op. at 3358-59 (9th Cir. Mar. 5, 2010) (*California Pharmacists II*). Here, Plaintiffs provided evidence of financial loss under each of the four categories of hospital services. With regard to inpatient services, Plaintiffs submitted evidence that no non-contract hospital would receive more than 90 percent of costs, while one-third of hospitals would receive less than 55 percent of their costs. Prior to AB 5 and AB 1183, 87 of the 95 affected hospitals were reimbursed between 95 and 100 percent for inpatient services. As to Distinct Part Nursing Facilities, prior to AB 5 and AB 1183, 84 percent of costs were reimbursed, whereas only 79 percent would be reimbursed under AB 1183, and many facilities would receive less than half of their

costs. Reimbursement for costs of subacute services would decrease from 98 to 93 percent for non-ventilator service providers and from 95 to 91 percent for ventilator service providers. And for outpatient services, reimbursement would decrease from 43 to 41 percent. Thus, Plaintiffs submitted substantial evidence demonstrating providers' financial loss under each of the four categories of hospital services. Such harm is to be considered irreparable in light of the State's Eleventh Amendment sovereign immunity. *California Pharmacists I*, 563 F.3d at 852. Accordingly, the district court abused its discretion in holding that the evidence submitted by Plaintiffs did not demonstrate a likelihood of irreparable harm.

We affirm the district court's holding as to Plaintiffs' likelihood of success on the merits for the reasons discussed in *California Pharmacists II*, slip op. at 33341-56.

We note that while the district court did not reach the issues of the balance of hardships and public interest with respect to Plaintiffs, it held in the related case dealing with adult-day health care centers that both factors weighed in favor of injunctive relief. We agree, and for the reasons set forth in *California Pharmacists II*, slip op. at 3360, hold that a preliminary injunction would be in the public interest. *See also California Pharmacists I*, 563 F.3d at 852-53.

For these reasons and those we provided in *California Pharmacists II*, slip op. at 3331-61, we

reverse the district court's denial of a preliminary injunction, and remand for it to enjoin AB 1183's five percent Medi-Cal reimbursement rate reduction as to the hospital services detailed *supra*.

**REVERSED and REMANDED.**

FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

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| CALIFORNIA PHARMACISTS ASSOCIATION, et al.,<br>Plaintiffs-Appellants,<br>v.<br>DAVID MAXWELL-JOLLY, Director of the Department of Health Care Services, State of California,<br>Defendant-Appellee. | No. 09-55365<br>D.C. No. 2:09-cv-722-CAS-MAN<br>Central District of California, Los Angeles<br>ORDER<br>(Filed Apr. 6, 2009) |

Before: REINHARDT, BERZON, and M. SMITH, Circuit Judges.

Plaintiffs-Appellants, the California Pharmacists Association, et al., filed this suit to challenge the Medi-Cal reimbursement rate reductions to various providers as set forth in AB 1183. A group of the plaintiffs, the Hospital Plaintiffs, which comprises the California Hospital Association and some individual hospitals, filed a motion in the district court for a preliminary injunction to enjoin the defendant from reducing Medi-Cal fee-for-service rates to hospitals,[1] arguing that AB 1183 was enacted in

[1] Specifically, the Hospital Plaintiffs sought to enjoin the rate reductions as to four types of services: (1) inpatient services

(Continued on following page)

violation of § 1396a(a)(30)(A) of Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* ((a)(30)(A)). The district court denied the preliminary injunction. The Hospital Plaintiffs filed an Emergency Motion Pursuant to Circuit Rule 27-3 for Preliminary Injunction Pending Appeal.

We review the denial of a preliminary injunction for abuse of discretion. *Earth Island Inst. v. U.S. Forest Serv.*, 442 F.3d 1147, 1156 (9th Cir. 2006). A district court abuses its discretion in denying a request for a preliminary injunction if it "base[s] its decision on an erroneous legal standard or clearly erroneous findings of fact." *Id.* (citation omitted). It also does so if in reaching its decision it makes a material error of law. We review conclusions of law de novo and findings of fact for clear error. *Id.*

Plaintiffs seeking a preliminary injunction in a case in which the public interest is involved must establish that they are likely to succeed on the merits, that they are likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in their favor, and that an injunction is in the public interest. *Winter v. Natural Res. Def. Council, Inc.*, 129 S. Ct. 365, 376 (2008). When deciding whether to issue a stay, including a stay of a state action that the district court has declined to enjoin, we consider: (1) whether the stay applicant

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for non-contract hospitals, (2) outpatient services, (3) Distinct Part Nursing Facilities, and (4) subacute services.

has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies. *See Humane Soc'y of U.S. v. Gutierrez*, 527 F.3d 788, 789-90 (9th Cir. 2008).

In this case, the district court found that the Hospital Plaintiffs were likely to succeed on the merits, but that they failed to demonstrate irreparable harm. We address these issues in turn, and, in view of the time-urgency and the irreparability of the harm, also consider the other *Winter* factors which necessarily follow.

## I. Likelihood of Success on the Merits

In *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), we held that 42 U.S.C. § 1396a(a)(30)(A) requires the state to consider efficiency, economy, quality of care, and access before setting Medi-Cal reimbursement rates. *Id.* at 1496. The district court concluded that the Hospital Plaintiffs have shown a likelihood of success on the merits under *Orthopaedic* because the Legislature did not consider any such factors before passing the rate cuts in AB 1183. The court ruled that although the Department of Health Care Services (the Department) had performed some studies after AB 1183's passage, those post-hoc studies failed to meet the requirements of *Orthopaedic*, 103 F.3d at 1496. It noted that AB 1183 gives the

Department no discretion to alter the rate cuts based on the Department's own analysis, and, therefore, the cuts were not "based on" the Department's consideration of the relevant factors, but instead constituted a post-hoc rationalization for a legislative decision that had already been made. Op. at 9-11. Moreover, the district court determined that, although the state Legislative Analyst Office issued a report analyzing the proposed cuts, there was no evidence the legislature actually considered the report before enacting AB 1183. *Id.* at 10 n.8.

We conclude that the district court did not abuse its discretion in concluding that the Hospital Plaintiffs demonstrated a likelihood of success on the merits. Indeed, the Hospital Plaintiffs made a strong showing of such likelihood.

## II. Irreparable Harm

The Hospital Plaintiffs must also show a likelihood of irreparable harm. *See Winter*, 129 S.Ct. at 375.

### A. Harm

We first address the type of harm we may consider in the irreparable harm analysis. The Department argues that only harm to Medi-Cal beneficiaries is relevant to this motion, while the Hospital Plaintiffs assert that harm to Medi-Cal service providers is also relevant, and that they need show only the latter

type of harm, in this case harm to themselves or their members, in order to obtain injunctive relief. The Hospital Plaintiffs further claim that they or their members will lose considerable revenue between the effective date of AB 1183 and the date their claims can be reviewed on the merits if injunctive relief is denied.

We agree with the Hospital Plaintiffs. In *Independent Living Center v. Shewry* (*ILC*), we held that "a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right,' in the sense that term has recently been used in suits brought under § 1983, but need only satisfy traditional standing requirements." 543 F.3d 1050, 1058 (9th Cir. 2008). We rejected the contention that federal statutes enacted pursuant to Congress's spending power, such as the one here at issue, are excluded from this principle, *id.* at 1059-62, and concluded that the health care providers in that case (which at that point did not include hospitals) had standing because:

> [A]ccording to their complaint, [they] will be "directly injured, by loss of gross income," when the ten-percent rate reduction takes effect. The Supreme Court "repeatedly has recognized that such [direct economic] injuries establish the threshold requirements" of Article III standing. . . . Moreover, this injury is directly traceable to the Director's implementation of AB 5 [the statute at issue in that case], and would certainly be redressed

> by a favorable decision of this court enjoining the ten-percent rate reduction.

*Id.* at 1065. Notably, *ILC* did *not* indicate that the service providers had standing to assert the interests of the beneficiary plaintiffs as third parties, as, for example, the medical service providers do in cases concerning the constitutional rights of patients. *See, e.g., Eisenstadt v. Baird,* 405 U.S. 438 (1972). A cause of action based on the Supremacy Clause obviates the need for reliance on third-party rights because the cause of action is one to enforce the proper constitutional structural relationship between the state and federal governments and therefore is not rights-based. In contrast, a case brought to enforce the Due Process or Equal Protection Clauses is rights based, and requires that the rights of *someone* be advanced, even if not the rights of the plaintiffs who have been injured.

Consistent with this understanding, in the various precedents cited throughout the *ILC* opinion in which plaintiffs brought cases directly under the Supremacy Clause, the interests asserted were basically economic, and there was no inquiry into whether the plaintiffs asserting the economic injury were in any sense intended beneficiaries of the federal statute on which the Supremacy Clause cause of action was premised. For example, in *Bud Antle, Inc. v. Barbosa,* one of the cases upon which we relied in *ILC,* we held that employers could sue to enjoin a California statute as preempted by the National Labor Relations Act (NLRA) "regardless of whether the NLRA conferred a

federal 'right' on employers." 45 F.3d 1261, 1271 n.13 (9th Cir. 1994). It was for that very reason that we concluded the § 1983 cases were inapposite, and that *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), did not preclude the plaintiffs' suit. Essentially, the line of cases on which we relied held that private parties could enforce the structural relationship between the federal and state governments so long as they had Article III standing as, essentially, private enforcers of the Supremacy Clause; the specific relationship of those parties to the federal statute on which the Supremacy Clause cause of action is premised does not matter.

Given these underpinnings of *ILC*, there is little basis on which to import an "intended beneficiary" concept back into the case for purposes of determining irreparable injury. Applying this determination to the present motion, it is clear that AB 1183 harms the Hospital Plaintiffs and their members through reductions in Medi-Cal revenue payments.

### B. Irreparability of Harm

Having determined that the Hospital Plaintiffs have shown unlawful harm under § (a)(30)(A), we next consider whether the harm is irreparable. Typically, monetary harm does not constitute irreparable harm. *L.A. Mem'l Coliseum Comm'n v. Nat'l Football League*, 634 F.2d 1197, 1202 (9th Cir. 1980). The Hospital Plaintiffs argue that in this case, however, the monetary injury is irreparable because the Eleventh

Amendment sovereign immunity of the Department (a branch of the State of California government) bars the Hospital Plaintiffs from ever recovering damages in federal court. The most relevant authority on this issue – though not controlling – supports the Hospital Plaintiffs' argument. *See Kan. Health Care Ass'n v. Kan. Dep't of Soc. & Rehab. Servs.*, 31 F.3d 1536, 1543 (10th Cir. 1994) ("Because the Eleventh Amendment bars a legal remedy in damages . . . the court held that plaintiffs' injury was irreparable. We agree."). We note also that Supreme Court case law and some of our own cases clarify that economic damages are not traditionally considered irreparable *because the injury can later be remedied by a damage award. See Sampson v. Murray*, 415 U.S. 61, 90 (1974) ("[I]t seems clear that the temporary loss of income, ultimately to be recovered, does not usually constitute irreparable injury. . . . The possibility that adequate compensatory or other corrective relief will be available at a later date, in the ordinary course of litigation, weighs heavily against a claim of irreparable harm." (internal quotation omitted)); *Rent-A-Center, Inc. v. Canyon Television & Appliance Rental, Inc.*, 944 F.2d 597, 603 ("It is true that economic injury alone does not support a finding of irreparable harm, *because such injury can be remedied by a damage award.*" (emphasis added)); *Caribbean Marine Servs. Co. v. Baldridge*, 844 F.2d 668, 676 (9th Cir. 1988); *Arcamuzi v. Cont'l Air Lines, Inc.*, 819 F.2d 935, 938 (9th Cir. 1987); *Colo. River Indian Tribes v. Town of Parker*, 776 F.2d 846, 850-51 (9th Cir. 1985); *Goldie's Bookstore, Inc. v. Superior Court*, 739 F.2d 466, 471

(9th Cir. 1984) ("Mere financial injury . . . will not constitute irreparable harm *if adequate compensatory relief will be available in the course of litigation.*" (emphasis added)).

Because the economic injury doctrine rests only on ordinary equity principles precluding injunctive relief where a remedy at law is adequate, it does not apply where, as here, the Hospital Plaintiffs can obtain no remedy in damages against the state because of the Eleventh Amendment. *See Kan. Health Care Ass'n*, 31 F.3d at 1543.[2]

Considering the relevant authorities, we are persuaded that because the Hospital Plaintiffs and their members will be unable to recover damages against the Department even if they are successful on the merits of their case, they will suffer irreparable harm if the requested injunction is not granted.

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[2] We observe that, although damages may become available to the Hospital Plaintiffs in state court, persuasive authority suggests that federal courts may consider only what *federal* remedies are available. *See United States v. New York*, 708 F.2d 92, 93-94 (2d Cir. 1983) (per curiam) (holding that "federal courts may consider only the available *federal* legal remedies"). *But see Kan. Health Care Ass'n*, 31 F.3d at 1543 ("Because the Eleventh Amendment bars a legal remedy in damages, *and the court concluded no adequate state administrative remedy existed*, the court held that plaintiffs' injury was irreparable. We agree." (emphasis added)). We find the reasoning of *New York* to be more persuasive, and consider *only* prospective federal remedies for the purpose of gauging whether the harm caused to the Hospital Plaintiffs and their members is irreparable.

**III. Equities and the Public Interest**

The district court did not reach the question of the equities and the public interest. Although the state argues that these factors weigh in its favor because an injunction will worsen the state's budget crisis, the record reflects that the impact of a stay on the budget crisis will be minimal at most. Further, it is clear that it would not be equitable or in the public's interest to allow the state to continue to violate the requirements of federal law, especially when there are no adequate remedies available to compensate the Hospital Plaintiffs for the irreparable harm that would be caused by the continuing violation. In such circumstances, the interest of preserving the Supremacy Clause is paramount. *See Am. Trucking Ass'n v. City of Los Angeles*, ___ F.3d ___, 2009 WL 723993, at *12 (9th Cir. Mar. 20, 2009) (considering the public interest represented by "the Constitution's declaration that federal law is to be supreme").

In light of the showing made by the Hospital Plaintiffs in this case, we grant their motion for an order staying the rate cuts in AB 1183 with respect to the specified hospital services pending their appeal to this court of the district court's order denying the motion for preliminary injunction.

**MOTION FOR STAY PENDING APPEAL IS GRANTED.**

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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| CALIFORNIA PHARMACISTS ASSOCIATION, et al.,<br>Plaintiffs-Appellants,<br>v.<br>DAVID MAXWELL-JOLLY, Director of the Department of Health Care Services, State of California,<br>Defendant-Appellee. | No. 09-55365<br>D.C. No. 2:09-cv-722-CAS-MAN<br>Central District of California, Los Angeles<br>ORDER<br>(Filed Aug. 24, 2009) |

Before: REINHARDT, W. FLETCHER, and M. SMITH, Circuit Judges.

The panel has unanimously voted to deny the petition for rehearing en banc. The full court has been advised of the petition for rehearing en banc and no judge of the court has requested a vote on it. Fed. R. App. P. 35.

The petition for rehearing en banc is DENIED.

**NOT FOR PUBLICATION**

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

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| INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC.; et al., Plaintiffs-Appellees, v. DAVID MAXWELL-JOLLY, Director of Department of Health Care Services of the State of California, Defendant-Appellant. | No. 09-55692<br>D.C. No. 2:09-cv-00382-CAS-MAN<br>MEMORANDUM*<br>(Filed Mar. 3, 2010) |

Appeal from the United States District Court
for the Central District of California
Christina A. Snyder, District Judge, Presiding.

Argued and Submitted Jan. 19, 2010.
Pasadena, California

Before: REINHARDT, W. FLETCHER and M. SMITH, Circuit Judges.

Plaintiffs-Appellees Independent Living Center of Southern California, Inc., et al. sought a preliminary injunction in the district court to enjoin

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* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

AB 1183's five percent Medi-Cal reimbursement rate reduction as to providers of pharmacy services. As the facts and procedural history are familiar to the parties, we do not recite them here except as necessary to explain our decision. We affirm the district court's grant of the preliminary injunction.

For the reasons discussed in *Cal. Pharms. Ass'n v. Maxwell-Jolly*, No. 09-55532, slip op. at 3331-3361 (9th Cir. Mar. 3, 2010) (*California Pharmacists II*), we reject the Director's contention that the State legislature was not required to study the impact of the five percent rate reduction on the statutory factors of efficiency, economy, quality, and access to care, prior to enacting AB 1183.

The primary issue in this appeal is whether the legislature actually conducted the requisite analysis prior to enacting AB 1183. At oral argument, the Director called our attention to a December 2007 Survey of Dispensing and Acquisition Costs of Pharmaceuticals in the State of California, which was prepared for the Department by the accounting firm Myers and Stauffer LC (the Myers and Stauffer Study). The Director referenced the Myers and Stauffer Study in its briefing before the district court, but only to support the argument that the *Department* had sufficiently considered the § 30(A) factors prior to *implementing* the five percent rate reduction. However, for the reasons we explained in *California Pharmacists* II, slip op. at 3349-3355, any analysis performed by the Department was inadequate because the Department did not retain the discretion

not to implement the rate reductions based on a § 30(A) analysis.

On appeal, the Director argues that the *legislature* also considered the Myers and Stauffer Study, because it appears in the "Comments" column of the May 30, 2008 agenda released by the Assembly Budget Subcommitee No. 1 on Health and Human Services. That comment reads: "Dec. 2007 Myers and Stauffer study found that current Medi-Cal drug pricing averages around 5 percent over cost." The Director did not argue in his briefing, either here or in the district court, that the citation to the Myers and Stauffer Study in the May 2008 agenda satisfied § 30(A)'s requirements. However, the Director presented the agenda to the district court as part of AB 1183's legislative history, and the district court held that the legislative history shows no indication that the § 30(A) factors were considered. We have held that the district court's finding on that issue was not clearly erroneous. *See California Pharmacists II*, slip op. at 3349.

In any event, for two additional reasons, we reject the Director's reliance on the Myers and Stauffer Study to satisfy the requirement that the *legislature* "stud[ied] the impact of the contemplated rate change(s) on the statutory factors prior to setting rates, or in a manner that allow[ed] those studies to have a meaningful impact on rates before they [were] finalized." *California Pharmacists II*, slip op. at 3360-61 (emphasis omitted). First, the one-sentence citation to the May 30, 2008 agenda does not show

adequate consideration of the § 30(A) factors. Second, while the Myers and Stauffer Study provides a detailed discussion of costs, it is bereft of any analysis of the remaining § 30(A) factors – efficiency, economy, quality, and access to care. *See California Pharmacists II*, slip op. at 3360 (holding that the State must consider costs *and* study the impact of the rate change on the statutory factors). Indeed, the Myers and Stauffer Study notes several times that it is only a cost study, and recommends that the Department conduct additional analysis in light of those costs. *See, e.g.*, Myers and Stauffer Study at 79 ("There are several factors that should be considered in determining an appropriate pharmacy reimbursement formula for Medi-Cal. These factors include dispensing costs . . . , drug acquisition costs and market dynamics . . . balanced with the need to maintain sufficient access to services for Medi-Cal recipients throughout the state."); *id.* ("Myers and Stauffer recommends that the Department of Health Services evaluate its pharmacy participation level as well as any additional data sources available for tracking complaints about recipient access to services."); *id.* at 81 ("The cost survey performed by Myers and Stauffer reports aggregate historical costs of dispensing as observed in the current provider community but does not determine if the costs observed are reflective of providers operating in the most efficient manner possible."); *id.* ("An evaluation of the dispensing fee should also consider issues of access to services, reimbursement rates prevalent in the marketplace from other third party payers and payment rates that

promote incentives for provider efficiency."). Accordingly, we affirm the district court's holding concerning Plaintiffs' likelihood of success on the merits because the State did not study the impact of the five percent rate reduction on the statutory factors prior to enacting AB 1183, or in a manner that allowed those studies to have a meaningful impact on rates before they were finalized. *See California Pharmacists II*, slip op. at 3360-61.

Nor did the district court abuse its discretion in finding that Plaintiffs demonstrated irreparable harm. After considering both parties' evidence, the district court concluded that the Director failed to refute Plaintiffs' showing of irreparable harm. The district court concluded that even if, on average, pharmacies would be compensated above their acquisition costs, the Director had not refuted Plaintiffs' showing that many brand and generic drugs would be reimbursed at a level below cost, limiting Medi-Cal patients' access to those drugs. The district court noted that because many single-source drugs are protected from competition by patents, there are no available generic alternatives. The court also concluded that if pharmacies are forced to curtail services or go out of business, existing customers would not have access to other pharmacies, especially since home-delivery services would end. It further noted that independent pharmacies represent thirty-three percent of the licensed community pharmacies in California and that they would be severely impacted by the reductions.

Contrary to the Director's argument, the district court did not disregard the Director's evidence, and the Director cannot rely solely on asking this court to reweigh the evidence presented to the district court. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 658 (9th Cir. 2009). The district court's conclusion that Plaintiffs would suffer irreparable harm was not clear error.

The district court also did not abuse its discretion in determining that the balance of hardships tipped decidedly in Plaintiffs' favor. *See California Pharmacists II*, slip op. at 3360.

For these reasons and those we provided in *California Pharmacists II*, slip op. at 3331-61, we affirm the district court's grant of a preliminary injunction. **AFFIRMED.**

**FOR PUBLICATION**

**UNITED STATES COURT OF APPEALS**
**FOR THE NINTH CIRCUIT**

LYDIA DOMINGUEZ, by and through her mother and next friend Lisa Brown; ALEX BROWN, by and through his mother and next friend Lisa Brown; DONNA BROWN, by and through her conservator and next friend Julie Weissman-Steinbaugh; CHLOE LIPTON, by and through her conservator and next friend Julie Weissman-Steinbaugh; HERBERT M. MEYER, on behalf of themselves and a class of those similarly situated; LESLIE GORDON, on behalf of themselves and a class of those similarly situated; CHARLENE AYERS, on behalf of themselves and a class of those similarly situated; WILLIE BEATRICE SHEPPARD, on behalf of themselves and a class of those similarly situated; ANDY MARTINEZ, on behalf of themselves and a class of those similarly situated; SERVICE EMPLOYEES INTERNATIONAL UNION UNITED HEALTH CARE WORKERS WEST; SERVICE EMPLOYEES INTERNATIONAL UNION UNITED LONG-TERM CARE WORKERS; SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 521;

No. 09-16359

D.C. No.
4:09-cv-02306-CW

OPINION

SERVICE EMPLOYEES INTERNATIONAL UNION CALIFORNIA STATE COUNCIL,

*Plaintiffs-Appellees*,

v.

ARNOLD SCHWARZENEGGER, Governor of the State of California; JOHN A. WAGNER, Director of the California Department of Social Services; DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services; JOHN CHIANG California State Controller,

*Defendants-Appellants*,

and

FRESNO COUNTY; FRESNO COUNTY IN-HOME SUPPORTIVE SERVICES PUBLIC AUTHORITY,

*Defendants*.

Appeal from the United States District Court
for the Northern District of California
Claudia Wilken, District Judge, Presiding

Argued and Submitted
January 19, 2010 – Pasadena, California

Filed March 3, 2010

Before: Stephen Reinhardt, William A. Fletcher and Milan D. Smith, Jr., Circuit Judges.

Opinion by Judge Milan D. Smith, Jr.

## COUNSEL

Stephen P. Berzon, Scotta A. Kronland, Stacey M. Leyton, Peder J. Thoreen, and Anne N. Arkush of Altshuler Berzon LLP, San Francisco, California, for the plaintiffs-appellees.

Edmund G. Brown, Jr., Attorney General of California, Douglas N. Press, Senior Assistant Attorney General, Susan M. Carson, Supervising Deputy Attorney General, and Gregory D. Brown and Michael A. Zwibelman, Deputy Attorneys General, San Francisco, California, for the State defendants-appellants.

## OPINION

MILAN D. SMITH, JR., Circuit Judge:

In 1973, the State of California established the In-Home Supportive Services (IHSS) program to provide in-home assistance and care to low-income elderly and disabled persons who otherwise would be unable to remain safely in their homes. *See* Cal. Welf. & Inst. Code § 12300. Plaintiffs-Appellees, a putative class comprised of recipients of the State's IHSS program and the unions who represent IHSS providers, seek to enjoin state legislation that reduces the state contribution to wages paid to IHSS providers because it is preempted by Section 30(A) of the Medicaid Act. The district court issued a preliminary injunction. We affirm.

## FACTUAL AND PROCEDURAL BACKGROUND

Under Title XIX of the Social Security Act (the Medicaid Act), 42 U.S.C. § 1396 *et seq.*, the federal government grants states funds to use towards state-administered programs that provide medical assistance to low income individuals.[1] To receive federal funds, states must administer their programs in compliance with individual "State plans for medical assistance," which require approval by the federal Secretary of Health and Human Services. 42 U.S.C. § 1396-1. The California Department of Health Care Services (Department) is designated the "single State agency established or designated to administer or supervise the administration of the [State] plan." 42 C.F.R. § 431.10(b).

IHSS is one of the programs for which California receives federal funding under its version of Medicaid, known as Medi-Cal. Medi-Cal operates via a prospective reimbursement system, whereby the State "sets reimbursement rates for specific services, regardless of where those services are performed." *Orthopaedic*, 103 F.3d at 1493. IHSS recipients

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[1] For a more detailed discussion of the Medicaid Act, we refer the reader to our prior decisions. *See, e.g., Cal. Pharm. Ass'n v. Maxwell-Jolly*, slip op. at 3331-61 (9th Cir. March 3, 2010) (*California Pharmacists II*); *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) (*Independent Living II*); *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (*Independent Living I*); *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997).

receive a host of "supportive services . . . [,] which make it possible for the recipient to establish and maintain an independent living arrangement." Cal. Welf. & Inst. Code § 12300(b). These services, which are provided in the beneficiary's home, include assistance with ambulation, bathing, oral hygiene, grooming, dressing, bowel and bladder care, feeding, and self-administration of medications. *Id.* § 12300(b)-(d). There are over 360,000 IHSS providers serving 440,000 individuals in California; sixty-two percent of IHSS recipients receive care from an IHSS provider who is also a relative. In many cases, supportive services are provided by a parent, who is eligible to receive payment for caring for his or her child only upon leaving full-time employment or if the parent is unable to obtain full-time employment because no other suitable provider is available and the child would be left with inadequate care. *See* Cal. Welf. & Inst. Code § 12300(e).

The IHSS program is paid for and administered through a combination of federal, state, and county funds. The State has authorized counties to provide for the delivery of IHSS services by one of two methods: first, a county may hire IHSS providers directly; or second, a county may contract with a nonprofit consortium (NPC) or establish a public authority (PA) – an entity separate from the county that performs public and essential governmental functions necessary to deliver IHSS services. *See* Cal. Welf. & Inst. Code §§ 12302, 12301.6(a)-(b). Fifty-six of the State's fifty-eight counties have established a NPC or PA.

NPCs and PAs are considered employers of IHSS providers for purposes of collective bargaining over wages, hours, and other terms and conditions of employment, although IHSS recipients retain the right to hire, fire, and supervise the work of their individual IHSS provider. *Id.* § 12301.6(c).

In counties that have established a NPC or PA, wages and benefits are established through collective bargaining between the NPC or PA and the providers' union. Cal. Welf. & Inst. Code § 12301.6(c). Before any increase in wages or benefits may take effect, it must be approved by the Department, which determines whether the increase is consistent with federal law and ensures that federal financial participation is available. *Id.* § 12306.1(a).

For the IHSS program, the California legislature has directed the Department to establish a provider reimbursement rate methodology that: (1) is consistent with the functions and duties of NPCs and PAs; (2) "[m]akes any additional expenditure of state general funds subject to appropriation in the annual Budget Act"; and (3) "[p]ermits county-only funds to draw down federal financial participation consistent with federal law." *Id.* § 14132.95(j)(2)(A)(i)-(iii). In establishing its rate-setting methodology, the Department is also authorized to "[d]eem the market rate for like work in each county . . . to be the cap for increases in payment rates for individual practitioner services," and "[p]rovide for consideration of county input concerning the rate necessary to ensure access to services in that county." *Id.* § 14132.95(j)(2)(C).

Following the passage of the American Recovery and Reinvestment Act of 2009 (ARRA), the federal government contributes approximately sixty-two percent of the overall cost of the IHSS program.[2] Of the remaining "non-federal share," the State contributes sixty-five percent while the county contributes thirty-five percent. Cal. Welf. & Inst. Code § 12306(b). However, the State's contribution is subject to a statutory cap. Prior to implementation of the statute at issue in this case, California Welfare & Institutions Code § 12306.1(d)(6) (effective July 1, 2009), the State contributed sixty-five percent of the non-federal share up to $12.10 per hour. *Id.* § 12306.1(c)-(d). That statutory cap has increased over time, beginning at $8.10 per hour in 2000 and reaching $12.10 by way of four statutory increases. *See id.* § 12306.1(d)(1)-(5).

However, on February 20, 2009, the Governor signed § 12306.1(d)(6) into law. Scheduled to take effect July 1, 2009, § 12306.1(d)(6) reduces the statutory maximum for which the State would contribute its proportionate share for IHSS wages and benefits from $12.10 per hour to $10.10 per hour. In other words, the State's maximum contribution to wages and benefits would be reduced from sixty-five percent of the non-federal share of an hourly rate up to $12.10 to sixty-five percent of the non-federal share of an hourly rate up to $10.10.

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[2] Prior to enactment of the ARRA, the federal government contributed fifty percent of the program's costs.

The new law does not require counties to reduce wages and benefits paid to IHSS service providers. Counties are permitted to make up the difference between the State's current contribution and any reduction that may result from the State's decreased contribution. Currently, thirty-four of the fifty-six NPCs and PAs pay IHSS providers $10.10 per hour or less in wages and benefits, so there would be no reduction in the State's contribution in any of those counties, including Los Angeles County in which forty-two percent of all IHSS services are provided. Twenty-two counties are, however, directly affected by the rate change. According to Plaintiffs, in response to § 12306.1(d)(6), fourteen of those counties that were paying wages and benefits of more than $10.10 per hour have thus far submitted Rate Change Requests to the Department of Social Services (DSS), seeking to reduce wages effective July 1, 2009.[3] All of these Rate Change Requests were approved by DSS and the Department.

On May 26, 2009, Plaintiffs brought this action challenging § 12306.1(d)(6) under the Supremacy Clause, claiming that in enacting and implementing

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[3] On May 1, 2009, DSS issued All-County Information Notice No. I-34-09 notifying counties of § 12306.1(d)(6). The notice instructed: "Counties currently providing wages and individual health benefits above $10.10 must submit a PA Rate Change Request to reflect the change in the maximum amount in which the state will participate. A letter of intent to complete a Rate Change Request must be submitted to [DSS] by June 1, 2009 from each of the counties affected by the statutory change."

§ 12306.1(d)(6), the State failed to comply with the procedural and substantive requirements of 42 U.S.C. § 1396a(a)(30)(A) (hereafter § 30(A)).[4] After noting that the State conceded that the legislature did not consider the § 30(A) factors prior to adopting § 12306.1(d)(6), the district court granted the preliminary injunction. Defendants appealed.

## JURISDICTION AND STANDARD OF REVIEW

We have jurisdiction over this appeal pursuant to 28 U.S.C. § 1292(a)(1). A district court's decision to grant or deny a preliminary injunction is reviewed for abuse of discretion. *Indep. Living II*, 572 F.3d at 651. Reviewing for abuse of discretion, first, we "determine de novo whether the trial court identified the correct legal rule to apply to the relief requested." *United States v. Hinkson*, 585 F.3d 1247, 1262 (9th Cir. 2009) (en banc). If the trial court did not identify the correct legal rule, it abused its discretion. *Id.* Second, we must determine if the district court's "application of the correct legal standard was (1) 'illogical,' (2) 'implausible,' or (3) without 'support in inferences that may be drawn from the facts in the record.'" *Id.* (quoting *Anderson v. City of Bessemer City*, 470 U.S. 564, 577 (1985)).

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[4] Plaintiffs also alleged unlawful discrimination under the Americans with Disabilities Act and Rehabilitation Act. The district court did not address Plaintiffs' ADA or Rehabilitation Act claims and they are not before us on appeal.

In granting a request for a preliminary injunction, a district court abuses its discretion if it "base[s] its decision on an erroneous legal standard or clearly erroneous findings of fact." *Earth Island Inst. v. U.S. Forest Serv.*, 442 F.3d 1147, 1156 (9th Cir. 2006), *abrogated on other grounds by Winter v. Natural Res. Def. Council, Inc.*, 129 S. Ct. 365 (2008). We review conclusions of law de novo and findings of fact for clear error. *Id.* Under this standard, "[a]s long as the district court got the law right, it will not be reversed simply because the appellate court would have arrived at a different result if it had applied the law to the facts of the case." *Id.* (internal quotation marks omitted).

## DISCUSSION

In seeking a preliminary injunction in a case in which the public interest is involved, Plaintiffs must show that: (1) they are likely to succeed on the merits; (2) they are likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in their favor; and (4) an injunction is in the public interest. *Cal. Pharms. Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 849 (9th Cir. 2009) (*California Pharmacists I*) (citing *Winter*, 129 S. Ct. at 376); *see also Am. Trucking Ass'ns, Inc. v. City of Los Angeles.*, 559 F.3d 1046, 1052 (9th Cir. 2009).

## I. Likelihood of Success on the Merits

Section 30(A) provides that a State plan must "provide such methods and procedures relating to . . . the payment for . . . care and services . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care." 42 U.S.C. § 1396a(a)(30)(A) (hereafter § 30(A)). In *Orthopaedic*, we held that § 30(A) requires

> the Director [to] set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

103 F.3d at 1496. The principal issue in this appeal is whether the district court erred in holding that *Orthopaedic* applies to the State's enactment of California Welfare & Institutions Code § 12306.1(d)(6).

As we will explain, both the legislature and the Department recognize that reimbursement rates – that is, providers' wages and benefits – are directly correlated to ensuring that services are consistent with efficiency, economy, and quality of care, and sufficient to ensure access to services under the IHSS program. Following passage of § 12306.1(d)(6), counties, unsurprisingly, reduced the hourly wage paid to IHSS providers. As we explained in *Orthopaedic*,

"*payments* for [Medi-Cal] services must be consistent with efficiency, economy, and quality of care, and . . . those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." 103 F.3d at 1496. Because section 12306.1(d)(6) directly affects what Medi-Cal providers are *paid* for providing services, it falls within § 30(A). Thus, we hold that before enacting legislation that has the effect of lowering payments to providers – here, § 12306.1(d)(6) – the State must study the impact of that decision on the statutory factors set forth in § 30(A). *See California Pharmacists II*, slip op. at 3346.

### A. The Application of § 30(A) to Cal. Welf. & Inst. Code § 12306.1(d)(6)

The State argues that *Orthopaedic* does not apply to § 12306.1(d)(6) because that section does not *set* medical reimbursement rates. According to the State, *Orthopaedic* is concerned with ensuring that the State follows adequate procedures to assure that reimbursement rates are consistent with the statutory factors set forth in § 30(A) – efficiency, economy, access, and quality of care. However, § 12306.1(d)(6) neither sets rates, nor changes the procedure in place, i.e., the collective bargaining process, to ensure that wages and benefits paid to IHSS providers are consistent with those statutory factors. Rather, § 12306.1(d)(6) merely lowers the State's *contribution* toward wages and benefits set by the counties pursuant to collective bargaining.

We are not persuaded by the State's attempt to distinguish its rate of *reimbursement* to providers from its *contribution* to the amount counties pay providers in the IHSS context. The State claims that it has removed itself from the rate-setting process and left it up to the counties and providers to negotiate rates through collective bargaining. However, by limiting its contribution to its portion of the non-federal share, the State injects itself *into* the collective bargaining process. Indeed, the statutory cap that the State sets on its contribution provides a powerful bargaining chip to both providers and NPCs or PAs during negotiations over wages and benefits. Prior to § 12306.1(d)(6), providers could seek hourly wages and benefits up to $12.10 knowing that counties would have to contribute just 35 percent of their non-federal share. After the passage of the current § 12306.1(d)(6), providers confront the reality that any hourly wage above $10.10 would be borne entirely by the county.

Similarly, the State argues that the collective bargaining process is an adequate procedure under *Orthopaedic* to assure that rates are consistent with efficiency, economy, and quality of care, and sufficient to ensure access. That may be true, though we note that nothing in the record demonstrates that the Department has conducted any analysis or study regarding the effect of the collectively bargained rates on the statutory factors. But, in any event, Plaintiffs are not challenging those collectively bargained rates, nor are they challenging the collective bargaining process as a method of establishing rates. Rather,

they are challenging the procedural adequacy of the legislature's decision to decrease its funding of those rates. As we have explained, decreasing the amount the State contributes to those rates is as integral to the collective bargaining process as the negotiations themselves, because it directly impacts the amount at which rates will ultimately be set.

The record proves the point in this case. Approximately fourteen counties submitted Rate Change Requests after receiving notice of § 12306.1(d)(6). At least two of those Rate Change Requests expressly state that the decision to reduce the hourly wage for IHSS providers "is due to the change in the State Participation Rate, effective July 1, 2009." These changes demonstrate that the amount the State determines it will contribute to IHSS providers' wages and benefits alters the amount counties are willing to pay IHSS providers for their services – something that the State itself recognized as impacting IHSS recipients' access to services. *See* Cal. Welf. & Inst. Code § 14132.95(j)(2)(C).[5]

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[5] Indeed, in establishing the IHSS program, the State left the bulk of *administrative* duties to the counties. However, before entrusting the counties to administer the program, the State authorized counties to provide for the delivery of IHSS services by either contracting directly with IHSS providers or by establishing NPCs or PAs that would engage with providers in collective bargaining. *See* Cal. Welf. & Inst. Code § 12301.6(c). The State further directed the Department to establish a provider reimbursement rate methodology that would be consistent with the manner in which NPCs and PAs were constituted. *See*

(Continued on following page)

The Department itself has acknowledged the relationship between reimbursement rates and access to in-home supportive services. In the State plan, the Department has articulated its policy that "reimbursement rates for Personal Care Services shall not be less than levels necessary to achieve adequate access to these services, but shall not exceed the lesser of specified limits, consistent with the requirements of [§ 30(A)]." The State plan also provides that "[t]o the extent that the Department finds that sufficient access to services is available, any rate *increases* granted under this program shall be no greater than the funds appropriated by the Legislature for such purpose." (emphasis added). The Department has thus recognized that rate increases are subject to the availability of State funds and has expressly conditioned its approval over such increases on a finding that sufficient access to services is otherwise available. The corollary must also be true. That is, the same oversight exists for any decrease in rates brought about by the availability of State funds. The Department is thus well aware that prior to approving reimbursement rates established through collective bargaining, it must determine whether sufficient access to services is available. *Cf. Orthopaedic,* 103 F.3d at 1497 (rejecting the State's argument that it

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*id.* § 14132.95(j)(2)(A)(i). In directing the Department to consider a host of relevant factors in establishing its rate-setting methodology, the State recognized that the hourly wage at which providers would be paid would have a direct impact upon "access to services in that county." *Id.* § 14132.95(j)(2)(C).

does not have to pay the costs associated with quality of care because hospitals are required to provide such care as a result of contractual obligations and licensing requirements).

Likewise, the Department has recognized the direct link between the State's change in *contribution* rate and the resulting change in *reimbursement* rates. In April 2009, the Department sent the United States Department of Health and Human Services (HHS) an analysis of § 12306.1(d)(6), providing its arguments as to why § 12306.1(d)(6) did not violate newly enacted requirements of ARRA. That analysis explained the reduction in the State's contribution under § 12306.1(d)(6), including that "funding has been reduced so that the maximum wage participation level will be $10.10 per hour starting July 1, 2009. As a result, the State's conditional approvals of the PA rates are no longer effective and each of the counties in question will need to request the State's approval of another PA rate. . . . If in connection with that a county then chooses to negotiate different wages in excess of the $10.10 maximum wage participation level, it will be doing so voluntarily and not because of any State requirements." Thus, the State explicitly invalidated its prior approval of PA rates, previously negotiated via collective bargaining, as a result of § 12306.1(d)(6).

In any event, the State's obligation to consider whether providers' "payments are consistent with efficiency, economy, and quality of care," § (30)(A), is independent of whatever wages and benefits are set

pursuant to collective bargaining. Notably, in concluding that § 12306.1(d)(6) did not render the State ineligible for increased funding under ARRA, HHS advised the State that if the Department were to approve provider wage rates at a level less than that recommended by the county, "the State would need to assure that the lack of funding from local sources will not result in lowering the amount, duration, scope or quality of care and services available under the plan."

The State argues that there are in excess of 14,000 IHSS providers listed in county registries, implying that there can be no problem with "access" to services following the legislature's decision to cut its contribution to wages and benefits under § 12306.1(d)(6). But the fact that there were 14,000 available IHSS providers in county registries *before* § 12306.1(d)(6)'s rate cut took effect does little to ensure sufficiency of access to quality services after a reduction in wages and benefits. Regardless, as we explained in *Orthopaedic*, "[d]e facto access, produced by factors totally unrelated to reimbursement levels, does not satisfy the requirement of [§ 30(A)]." 103 F.3d at 1498. Sixty-two percent of IHSS recipients receive care from an IHSS provider who is also a relative. Allowing the State to rely on the fact that so many IHSS recipients depend on care from a relative, who may often have no other choice than to provide such services, would allow the State "to ignore the relationship of reimbursement levels to provider costs when determining whether payments are sufficient to ensure access to quality services." *Id.* Moreover, by

focusing on quantity of providers, the State fails to consider potential effects on quality of care.

The State's argument also misses the point. "We do not require plaintiffs to show the State has committed a substantive violation of § 30(A)'s access provision when they can show that the State did not comply with § 30(A)'s procedural components." *California Pharmacists II*, slip op. at 3357. Therefore, whether there were to remain an excess of available IHSS providers in county registries after the decrease in wages and benefits has little bearing on the State's procedural compliance with § 30(A). *See Independent Living II*, 572 F.3d at 657 (discussing this court's "process-oriented view" of § 30(A)).

### B. Consideration of Costs

The State next argues that *Orthopaedic* is inapposite to this case because *Orthopaedic* instructs the State to consider the costs to service providers when its sets reimbursement rates, 103 F.3d at 1496, but providers of IHSS services do not have "costs" that can be reimbursed. Rather, sixty percent of providers are spouses, parents, or other relatives of the beneficiaries, and approximately fifty percent live with the recipients they serve. The State contends that it would thus be "virtually impossible" for it to obtain "cost studies" with respect to IHSS services, and so *Orthopaedic*, which holds that states should consider costs, should not apply.

We rejected a similar argument in *Independent Living II*. There, the Director argued that there was "no established mechaniam for obtaining cost data from physicians on the costs they incur for providing each of these [covered] services." 572 F.3d at 652 (brackets in original) (internal quotation marks omitted). Having determined that § 30(A) clearly applied to the State's decision to cut providers' reimbursement rates, we rejected the Director's argument, and held that "[i]n the absence of such cost data, the Director could not have complied with § 30(A)." *Id.* The same holds true here. Since we have determined that the State should have studied the impact of its decreased contribution to providers' wages and benefits prior to passing § 12306.1(d)(6), the State is not *ipso facto* immunized from challenges to its actions because it had no system in place to make such an assessment.

Furthermore, there does not seem to be anything inherently difficult about studying IHSS providers' "costs" since there is undoubtedly a way to measure what it costs providers to care for IHSS recipients. The State argues that it cannot study costs because IHSS providers are providing "only their time and labor" and are not paid "rates for specific services, but rather receive hourly wages and benefits for the work they perform." We disagree. The hourly wage paid to an IHSS provider *is* the rate to which they are entitled for providing specific services. *See* Cal. Welf. & Inst. Code § 14132.95(j)(1) ("[R]eimbursement *rates* for personal care services shall be equal to the *rates*

in each county for the same mode of services in the [IHSS] program." (emphases added)). Indeed, those services are expressly enumerated in the governing statute. *See id.* § 12300(b).

In addition, while the State "need not follow a rigid formula," *Orthopaedic*, 103 F.3d at 1498, for determining what it costs providers to care for IHSS recipients, they must rely on something. The State offers nothing to support its assertion that it would be "nonsensical and virtually impossible" to comply with *Orthopaedic's* requirements in the IHSS context. To the contrary, the State concedes that the July 2008 Report to the Legislature, Public Authorities and Nonprofit Consortia in the Delivery of In-Home Supportive Services, SFY 2006/2007 (the July 2008 Report) contains extensive data regarding quality and access in the IHSS system, including: the number of providers available to work on provider registries for each county; data on service shortages and the availability of emergency back-up providers; data on PA/NPC rates and IHSS provider wages and benefits by county; data from provider and consumer satisfaction surveys and PA/NPC surveys; as well as what it costs PAs and NPCs to deliver services. In fact, the State argues that the July 2008 Report satisfies § 30(A)'s requirements – a contention to which we turn below. Yet, the State cannot have it both ways: either it is able to comply with § 30(A), or it is not.

At the very least, the State may look to what it costs providers of analogous services, such as in-home nursing care, as a means of considering providers'

costs. Indeed, in determining the "cap for increases in payment rates for individual practitioner services," the Department is similarly authorized to look to the market rate for "like work in each county." Cal. Welf. Inst. Code § 14132.95(j)(2)(C)(i).

Accordingly, we hold that the district court did not err in holding that § 30(A) applies to the State's enactment of § 12306.1(d)(6).

### C. State Compliance with § 30(A)

Next, the State argues that while it was under no obligation to do so, it complied with everything that *Orthopaedic* requires by preparing the 2008 Report. The district court did not consider this report because it believed that the State conceded that the legislature did not consider § 30(A) prior to enacting § 12306.1(d)(6).

We agree that, at oral argument before the district court, the State conceded that the legislature did not consider any analysis of the § 30(A) factors prior to enacting § 12306.1(d)(6). Not only did the State fail to raise this claim before the district court, thus waiving the issue, *see United States v. Flores-Montano*, 424 F.3d 1044, 1047 (9th Cir. 2005) (issues not raised to the district court are normally deemed waived subject to three "narrow exceptions"), it took the position that any consideration of § 30(A) would be impossible.

In any event, the 2008 Report is inadequate for purposes of § 30(A). Nowhere does the 2008 Report contain any references to § 12306.1(d)(6), let alone "study the impact of the contemplated rate change(s) on the statutory factors *prior to* setting rates, or in a manner that allows those studies to have a meaningful impact on rates before they are finalized." *California Pharmacists II*, slip op. at 3360-61. Rather, the 2008 Report is the annual report that DSS is statutorily required to provide the legislature, regarding the efficacy of counties' elections to establish a PA or contract with an NPC to deliver services. *See* Cal. Welf. & Inst. Code § 12301.6(o). While the annual report includes assessments of the quality of care being provided in the IHSS program, it contains no discussion of a contemplated rate change that would either increase or decrease payment rates. Finally, in the report on which the State relies, forty-three percent of PA/NPCs reported a "critical shortage of available providers that affected a specific subpopulation of IHSS consumers." That conclusion belies the State's assertion that current wages and benefits – those in effect prior to passage of § 12306.1(d)(6) – are consistent with § 30(A)'s statutory factors.

## II. Irreparable Harm

The State next argues that the district court erred in concluding that Plaintiffs established irreparable harm absent injunctive relief. In holding that Plaintiffs made a sufficient showing of irreparable harm, the district court made two factual findings,

which we review for clear error. *Earth Island Inst.*, 442 F.3d at 1156. First, the district court held that wage reductions would cause IHSS providers to leave employment, leaving IHSS recipients without IHSS assistance. Second, the district court concluded that IHSS providers would also suffer immediate and irreparable harm, due to the fact that a reduction in providers' wages and benefits would result in financial injury that providers would be unable to recover due to the State's Eleventh Amendment immunity.

On appeal, the State's primary argument is that Plaintiffs failed to submit any credible evidence that a reduction in the State's contribution, resulting in a decrease in wages to IHSS providers, would cause IHSS recipients to go without care. However, the State takes no position on whether Plaintiffs may establish irreparable injury to IHSS *providers* as opposed to IHSS *recipients*. As we stated in *California Pharmacists II*, to show a likelihood of irreparable injury, "plaintiffs need only show harm to Medi-Cal service providers or their members." Slip op. at 3358; *see also California Pharmacists I*, 563 F.3d at 850. Here, Plaintiffs have submitted ample evidence of harm to IHSS providers, including that fourteen counties have sought to reduce wages and benefits in the wake of § 12306.1(d)(6), which would impact many providers' ability to afford such basic necessities as food, clothing, utilities, and rent. Accordingly, we hold that the district court did not abuse its discretion in concluding that Plaintiffs established irreparable harm absent injunctive relief, as its

finding regarding provider harm was not clearly erroneous.

## III. Balance of Equities and the Public Interest

As to the final two elements necessary to obtain a preliminary injunction in a case in which the public interest is involved, we have repeatedly recognized that individuals' interests in sufficient access to health care trump the State's interest in balancing its budget. *See Independent Living II,* 572 F.3d at 659; *California Pharmacists II,* slip op. at 3360. (recognizing the important public interest in social welfare cases of safeguarding access to health care for Medicaid-eligible individuals). We continue to do so here, especially in light of evidence in the record that suggests that reductions in providers' wages and benefits may have an adverse, rather than beneficial, effect on the State's budget, such that it would actually save the State money if it maintained its current level of funding of the IHSS program. *See California Pharmacists I,* 563 F.3d at 852 (balance of equities and public interest weighed in favor of Medi-Cal providers where the impact of the injunction on the State's budget crisis would be minimal).

The State argues that if this injunction is upheld, "it will be unclear whether the State may ever undertake any action to reduce its payments" to Medi-Cal service providers. This statement wholly misreads our Medicaid jurisprudence. If the State makes a

policy decision to decrease providers' reimbursement rates, and fully complies with the requirements of this and our other decisions, it will not be barred by current federal Medicaid law from doing so. Accordingly, we hold that the district court did not abuse its discretion in concluding that the balance of hardships and the public interest weighed in favor of enjoining implementation of California Welfare & Institutions Code § 12306.1(d)(6).

## CONCLUSION

The district court properly determined that § 30(A) of the Medicaid Act applies to the State's enactment of California Welfare & Institutions Code § 12306.1(d)(6). The district court correctly held that Plaintiffs demonstrated a likelihood of success on the merits of their Supremacy Clause claim, and did not abuse its discretion in holding that the balance of hardships tips sharply in Plaintiffs' favor. Accordingly, we affirm the district court's order granting the motion for a preliminary injunction.

**AFFIRMED.**

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

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| California Pharmacists Association, et al.<br><br>Plaintiff(s),<br><br>vs.<br><br>David Maxwell Jolly<br><br>Defendant. | Case No.<br>CV 09-722 CAS (MANx)<br><br>**ORDER GRANTING PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AS TO ADULT DAY HEALTH CENTERS**<br><br>(Filed Mar. 9, 2009) |

## I. INTRODUCTION AND BACKGROUND

On September 16, 2008, the California Legislature passed Assembly Bill 1183 ("AB 1183"), which was subsequently signed by the Governor and filed with the Secretary of State on September 30, 2008. AB 1183, *inter alia*, amends Cal. Welf. & Inst. Code. § 14105.191 and §14166.245, mandating that, for dates of service on or after March 1, 2009, Medi-Cal reimbursement payments to some fee-for-service providers are reduced by one percent, five percent, or ten percent, depending on provider type. Particularly relevant to the instant action, AB 1183 mandates a five percent rate reduction for Medi-Cal fee-for-service benefits paid to pharmacies and Adult Day Health Centers ("ADHCs").

These reductions mandated in AB 1183 replace the ten percent rate reduction put into place by Assembly Bill X35 ("AB 5"), which terminates on February 28, 2009. *See* Cal. Welf. & Inst. Code § 14105.19(b)(1). AB 5 was passed by the California Legislature on February 16, 2008. On August 18, 2008, the ten percent rate reduction mandated by AB 5 was partially enjoined by this Court in a related action, *Independent Living Center of Southern California, Inc. v. Sandra Shewry*, CV-08-3315-CAS. In issuing the preliminary injunction, this Court found that petitioners had, *inter alia*, demonstrated a strong likelihood of success in showing that AB 5 was preempted by § 30(A) of the Medicaid Act (referred to herein as "§ 30(A)"). The Court's August 18, 2008 order is currently being appealed to the Court of Appeals for the Ninth Circuit.[1]

On January 29, 2009, plaintiffs California Pharmacists Association; California Medical Association; California Dental Association; California Hospital Association; California Association for Adult Day

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[1] The Court's August 18, 2008 order was issued on remand from the Ninth Circuit, after plaintiffs appealed this Court's original June 25, 2008 ruling on their preliminary injunction motion. The Court's June 25, 2008 order found that plaintiffs in Independent Living lacked any federal rights under § 30(A), and therefore had denied petitioners' motion for preliminary injunction. On appeal, the Ninth Circuit held that plaintiffs could bring suit under the Supremacy Clause to enjoin AB 5 as preempted under the Medicaid Act, and remanded to this Court. *See Independent Living Center of Southern California et al. v. Sandra Shewry et al.*, 543 F.3d 1050 (9th Cir. 2008).

Services; Marin Apothecary, Inc.; South Sacramento Pharmacy; Farmacia Remedios, Inc.; Acacia Adult Day Services; Sharp Memorial Hospital; Grossmont Hospital Corporation; Sharp Chula Vista Medical Center; Sharp Coronado Hospital and Healthcare Center; Fey Garcia; and Charles Gallagher filed the instant action against David Maxwell-Jolly, Director of the Department of Health Care Services of the State of California. Plaintiffs' complaint challenges the AB 1183 Medi-Cal reimbursement rate reductions to various providers.

On February 11, 2009, plaintiffs filed the instant motion for a preliminary injunction. Specifically, plaintiffs seek an order for a preliminary injunction restraining and enjoining the defendant from reducing Medi-Cal fee-for-service rates to pharmacies and adult day health care centers ("ADHCs") pursuant to AB 1183.

On February 27, 2009, this Court issued an injunction in the related case *Managed Pharmacy Care, et al. v. David Maxwell-Jolly,* CV09-382-CAS, ordering defendant "Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191(b)(3), as modified by AB 1183 beginning on March 1, 2009, by refraining from reducing by five percent payments to pharmacies for prescription drugs (including prescription drugs and traditional over-the-counter drugs provided by prescription) provided under the Medi-Cal fee-for-service program." Therefore, the Court considers

plaintiffs' request for an injunction as to pharmacies to be moot, and considers herein only their request for injunction as to ADHCs.[2]

On February 26, 2009, defendant filed an opposition to plaintiff's motion for preliminary injunction. A reply was filed on March 4, 2009. After carefully considering the arguments set forth by the parties, the Court finds and concludes as follows.

## II. LEGAL STANDARD

A preliminary injunction is appropriate when the moving party shows either (1) a combination of probable success on the merits and the possibility of irreparable harm, or (2) the existence of serious questions going to the merits and that the balance of hardships tips sharply in the moving party's favor.

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[2] In *Managed Pharmacy Care, et al. v. David Maxwell-Jolly*, CV09-382-CAS, plaintiffs' arguments regarding irreparable harm focused on brand and generic drugs dispensed by pharmacies. The Court therefore found that plaintiffs had not shown irreparable harm as to the effect of the five percent rate reduction on other pharmacy products, and limited the scope of the injunction to drug products dispensed by pharmacies.

In their reply, plaintiffs request that the Court rule on the merits of their motion for injunction as to pharmacies, arguing that the scope of the injunction requested in the instant action is broader than that granted in *Managed Pharmacy Care*, CV09-382-CAS. However, plaintiffs offer no basis for extending the scope of the injunction as to pharmacies issued in *Managed Pharmacy Care*, and, after examining the evidence submitted by plaintiffs in the instant action, the Court finds no basis for such an extension.

*See Rodeo Collection, Ltd. v. West Seventh*, 812 F.2d 1215, 1217 (9th Cir. 1987). These are not two distinct tests, but rather "the opposite ends of a single 'continuum in which the required showing of harm varies inversely with the required showing of meritoriousness.'" *Id.* A "serious question" is one on which the movant "has a fair chance of success on the merits." *Sierra On-Line, Inc. v. Phoenix Software, Inc.*, 739 F.2d 1415, 1421 (9th Cir. 1984).

## III. DISCUSSION

### A. ELEVENTH AMENDMENT AND PRUDENTIAL STANDING

Before addressing the merits of plaintiffs' argument for preliminary injunction, the Court must first address two arguments raised by defendant: (1) that plaintiffs' suit is barred by the Eleventh Amendment and (2) that plaintiffs lack standing. The Court finds that neither of these arguments is persuasive.

The essence of defendant's Eleventh Amendment argument is that plaintiffs' suit effectively amounts to a request for money damages to be paid out of the state treasury, in violation of the Eleventh Amendment. *See* Opp'n at 25, n.22 ("Plaintiffs seek to recover money against the State for funds above the 5% payment reduction"), citing *Edelman v. Jordan*, 415 U.S. 651 ("Thus the rule has evolved that a suit by private parties seeking to impose a liability which must be paid from public funds in the state treasury is barred by the Eleventh Amendment"). However,

the Court disagrees with defendant's characterization of plaintiffs' claim. Plaintiffs complaint does not seek money damages, but instead seeks only prospective injunctive relief – namely, an injunction preventing defendant from enforcing a state law that, defendants argue, is preempted by the Medicaid Act. Such prospective injunctive relief against a state official is permissible under *Ex Parte Young*, 209 U.S. 123 (1908), even where such an injunction will have an effect on the state treasury. *See, e.g., Milliken v. Bradley*, 433 U.S. 267 (federal courts permitted "to enjoin state officials to conform their conduct to requirements of federal law, notwithstanding a direct and substantial impact on the state treasury").

Defendant also argues that plaintiffs lack prudential standing, because they are health care providers who have no "rights" under the federal law they seek to enforce. Opp'n at 25, n.22. The Court disagrees. In its September 17, 2008 order in the related action *Independent Living*, 543 F.3d at 1065, the Ninth Circuit determined that petitioners in that action had standing:

> Petitioners include independent pharmacies and health care providers participating in the State's Medi-Cal program that, according to their complaint, will be directly injured, by loss of gross income, when the ten-percent rate reduction takes effect. The Supreme Court repeatedly has recognized that such [direct economic] injuries establish the threshold requirements of Article III standing. Moreover, this injury is directly traceable to

> the Director's implementation of AB 5, and would certainly be redressed by a favorable decision of this court enjoining the ten-percent rate reduction.

As in *Independent Living*, plaintiffs in the instant action include ADHC providers, who, plaintiffs allege, would be directly injured by the five percent Medi-Cal reimbursement rate reduction.

Furthermore, the Ninth Circuit in *Independent Living* noted that

> petitioners also include several individual Medi-Cal beneficiaries, who will be injured or put at risk of injury by implementation of the 10% provider payments cuts because those cuts will reduce quality services, and access to quality services. This injury, like the injury to medical providers discussed above, is the direct result of the Director's implementation of AB 5, and would certainly be remedied by a decision granting injunctive relief. Such an injury to those individuals most directly affected by the administration of [a state welfare] program is sufficient to allow petitioners to seek injunctive relief in federal court.

2008 U.S. App. LEXIS 19725 (9th Cir. 2008). Because plaintiffs in this case also include Medi-Cal beneficiaries who may be harmed by AB 1183 rate reductions, the Court finds defendant's argument that plaintiffs lack standing to be without merit.

## B. LIKELIHOOD OF SUCCESS ON THE MERITS

Pursuant to the holding of the Ninth Circuit in the related action *Independent Living*, 543 F.3d at 1065, the Court finds, as an initial matter, that plaintiffs may pursue a claim for relief under the Supremacy Clause based on the allegation that AB 1183 is preempted by § 30(A). Here, plaintiffs' Supremacy Clause claim is predicated upon federal conflict preemption. Under general principles of federal preemption, state law is preempted only to the extent that it actually conflicts with federal law. *Pacific Gas & Elec. Co. v. State Energy Comm'n*, 461 U.S. 190, 204 (1983). Such a conflict may arise either where "compliance with both federal and state regulations is a physical impossibility, or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id.* at 203-04 (citations omitted).

Thus, to prevail on the merits plaintiffs will have to prove either that it is not possible for the Department to comply with both AB 1183 and the Medicaid Act or that AB 1183 stands as an obstacle to the enforcement of § 30(A). As such, the Court turns to the statutory provisions at issue here.

The "quality of care" provision of § (30)(A) provides that:

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the

> payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care.

42 U.S.C. § 1396a(30)(A). The "equal access" provision of § 30(A) provides that:

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

*Id.*

In *Orthopaedic Hospital v. Kizer,* 1992 WL 345652 (C.D. Cal. 1992) ("*Orthopaedic I*"), plaintiff-hospital providers filed suit pursuant to 42 U.S.C. § 1983 ("§ 1983"), claiming that the Director violated § 30(A) by setting reimbursement rates for hospital outpatient services without considering the effect of hospital costs on efficiency, economy, and quality of

care.[3] *Id.* at *1. The district court concluded that § 30(A) was enforceable in a § 1983 action, and that the Department "had a judicially enforceable obligation" to consider and make findings each time it modified reimbursement rates. *Id.* at *2. According to the district court, § 30(A) obligated the Department to consider efficiency, economy, and quality of care, which it referred to as the "relevant factors." *Id.* at *4. The district court found that the Director had acted arbitrarily and capriciously in establishing six of the seven challenged rates. *Id.* The court then remanded the matter to the Department for further consideration. *Id.* at *14. Upon remand, the Department conducted a rate study, and readopted the reimbursement rates without change. *Orthopaedic Hospital II/III*, 103 F.3d at 1495.

The hospitals returned to the district court, filing two lawsuits (*Orthopaedic II/III*) that the district court consolidated, arguing that the adopted rates did not comply with § 30(A). *Id.* The district court entered judgment in favor of the Department, finding that the Department was not statutorily required to consider hospital costs when setting reimbursement rates. *Id.* The hospitals appealed, and the Ninth Circuit reversed. The Ninth Circuit's interpretation held that § 30(A) "provides that payments for services must be consistent with efficiency, economy, and quality of

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[3] The hospitals did not, however, challenge the rates under the "equal access" provision. *Orthopaedic I*, 1992 WL 345652 at *14 n.4.

care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Id.* at 1496 (emphasis in original). The Ninth Circuit therefore concluded that under § 30(A)

> the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

*Id.*[4] Further, the Ninth Circuit found that "[i]t is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons." *Id.* at 1499 n.3.[5]

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[4] *See e.g., Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-41 (9th Cir. 2005); *see also Arkansas Med. Soc'y v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) ("We agree with the trial court's conclusion that the relevant factors that DHS is obliged to consider in its rate-making decisions are the factors outlined in 42 U.S.C. § 1396a(a)(30)(A)."); *cf. Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding that § 30(A) does not require a state to consider any particular factors, but rather, requires that the state arrive at substantive results consistent with the Medicaid Act); *Rite Aid, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999) (same).

[5] Subsequently, in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), the Ninth Circuit held that § 30(A) does not confer

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Whatever else its effect may have been, it is clear that *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005) left undisturbed the rule announced in *Orthopaedic II/III* that § 30(A) creates duties on behalf of the Department, i.e., the duty to consider efficiency, economy, and quality of care when establishing reimbursement rates. Indeed, the *Sanchez* court recognized that "[§ 30(A)] speaks . . . of the *State's obligation* to develop 'methods and procedures' for providing services generally." *Sanchez*, 416 F.3d at 1059 (emphasis added).

Because *Orthopaedic II/III* is binding authority on this Court, the Court finds that when the State of California seeks to modify reimbursement rates for health care services provided under the Medi-Cal program, it must consider efficiency, economy, and quality of care, as well as the effect of providers' costs on those relevant statutory factors.

In the instant motion for preliminary injunction, plaintiffs argue that AB 1183's five percent reimbursement rate reduction to ADHCs is preempted by § 30(A), because the Legislature did not consider any

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individual rights that are enforceable under 42 U.S.C. § 1983. *Id.* at 1060. However, in *Independent Living*, 543 F.3d 1050 (9th Cir. 2008), the Ninth Circuit held that "a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right,' in the sense that term has been recently used in suits brought under § 1983, but need only satisfy traditional standing requirements." *Independent Living*, 543 F.3d 1050, 1058 (9th Cir. 2008).

of the relevant factors as required by *Orthopaedic II/III*. Specifically, plaintiffs argue that the legislative history indicates that the bill was passed solely for budgetary reasons, arguing that "AB 1183's legislative history presents no evidence that the Legislature made any consideration of efficiency, economy, quality of care, and equality of access, as well as the effect of providers' costs on those relevant statutory factors in the 24-hour period between AB 1183's amendment and its passage." Mot. at 13.

Defendants, however, argue that the requirements of *Orthopaedic II/III* are in fact satisfied, because the Department itself performed a detailed analysis of the relevant factors. Specifically, defendant submits the Department's report "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Adult Day Health Care Centers," ("Department ADHC Analysis"), completed in February 2009, well after the enactment of AB 1183 on September 16, 2008. Opp'n at 11. The Department ADHC Analysis concludes that:

> After a 5% payment reduction is implemented on March 1, 2009, Medi-Cal reimbursement paid to ADHCs will comply with title 42, United States Code, section 1396(a)(30)(A). The available data indicates that Medi-Cal recipients will continue to have sufficient access to ADHC services to the extent required by federal law. In fact they will actually have far better access to ADHC services than the general population does . . . The 5% payment reduction will

> result in more efficient and economical Medi-Cal coverage. It will not have any negative impact for Medi-Cal recipients. The number of ADHCs participating in Medi-Cal has tripled since 1998 and 94% of all licensed ADHCs are actively enrolled in Medi-Cal. Finally, the Department determined that Medi-Cal reimbursement will in the aggregate compensate provider costs at a level that is well above the 'range of reasonableness' that was acceptable under the repealed Boren Amendment. Thus, reduced reimbursement will be sufficient under the more flexible requirements of section 1396(a)(30)(A).

Department ADHC Analysis at 10-11.

Plaintiffs, however, argue that the Department's post-hoc analysis does not satisfy the requirements of *Orthopaedic II/III*. The Court agrees. First, the Court notes that AB 1183, as passed by the Legislature, does not provide the Department with any discretion to determine whether the five percent rate reduction should be implemented based on the Department's consideration of the relevant factors. *See* Cal. Welf. & Inst. Code. § 14105.191 ("Notwithstanding any other provision of law, or order to implement changes in the level of funding for health care services, the *director shall reduce* provider payments, as specified in this section . . . ") (emphasis added). In *Orthopaedic II/III*, in which rates set by the Department, rather than the Legislature, were at issue, the court stated that the "the Department must rely on responsible cost

studies, its own or others', that provide reliable data *as a basis* for its rate setting." 103 F.3d at 1496 (emphasis added); *see also id.* at 1499-1500 ("Since the Department did not adequately consider hospitals' costs *when readopting its rates*, the Department's actions were arbitrary and capricious and contrary to law") (emphasis added). The *Orthopaedic II/III* holding therefore indicates that the body responsible for rate setting must consider the relevant factors contemporaneously with the adoption of the rates. Because the Department has no authority to alter the rate reduction imposed by the Legislature, the Department's post hoc analysis does not satisfy the requirements of *Orthopaedic II/III*.

Furthermore, in this case, it does not appear that the Legislature appropriately considered any of the relevant factors before passing AB 1183. Defendant responds to plaintiffs' arguments that the legislature did not perform the required analysis by submitting evidence indicating that (1) between May 2008 and September 2008, Department employees provided information to legislative staff members concerning the rate reductions; (2) in June 2008, the Subcommittee 3 Health Human Services, Labor, and Veterans Affairs Major Action Report included modifications and rejections of certain rate reductions proposed by the Administration; and (3) in July 2008, the Summary Overview Budget Conference Committee Report includes discussions of the rate reductions. *See* Trueworthy Decl. ¶ 5, Exs. A-E. However, none of this demonstrates that the Legislature relied on

responsible cost studies providing reliable data in setting the rates. *See Orthopaedic Hospital II/III,* 103 F.3d at 1496. Furthermore, even if a post hoc analysis of the relevant factors was sufficient, the Court is not persuaded that the analysis actually conducted by the Department was adequate, given that the Department relied on NF-A data, which may not be an adequate proxy for ADHC costs. Reply at 12.

Therefore, because it appears that the Legislature and the Department did not properly consider the relevant factors prior to the passage of the five percent rate reduction in AB 1183, the Court finds that plaintiffs have a strong likelihood of success on the merits.

### C. IRREPARABLE HARM

The next question before this Court is whether plaintiffs have shown that Medi-Cal beneficiaries will be irreparably harmed if the five percent rate reduction to ADHCs is permitted to go into effect. Defendant argues that plaintiffs cannot show irreparable harm resulting from the five percent rate reduction to ADHCs, given that the Department ADHC Analysis estimates that after AB 1183, ADHCs will be compensated at a level above 100 percent of necessary and reasonable ADHC costs.[6] Mot. at 16-17;

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[6] The Department states that because it is in the process of auditing costs of ADHCs, it is not able to assess how current ADHC reimbursement in the aggregate compares to the

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Department ADHC Analysis at 8. Furthermore, with regard to access, defendants argue that, because Medicare and other health insurance plans do not cover ADHC services, ADHC services are not generally available to the general population, and therefore, "[p]laintiffs cannot meet their burden of proving that any payment reduction, let alone a 5% payment reduction, is going to affect access to services to which the general population has limited access in the first place." Mot. at 17; *see* Ferreria Decl. ¶ 3. In addition, defendant argues that, since 1998, an additional 212 ADHCs have enrolled in the Medi-Cal program, indicating that "for profit" ADHCs have found the reimbursement rate to be sufficiently profitable to join and remain in the Medi-Cal program. Mot. at 17; Department ADHC Analysis at 10. Finally, the Department's ADHC Analysis found that when the ten percent rate reduction was in effect between July 1, 2008 and August 17, 2008, there was only a two percent decrease in paid ADHC claims compared to a similar period the prior year, indicating that a more moderate reduction will not result in a decrease in access. Mot. at 18; ADHC Analysis at 10.

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reasonable and allowable costs that ADHCs incur. *See* Eng Decl. ¶ 4. Therefore, the Department's analysis uses as a proxy the costs of intermediate care facilities ("NF-As"). Plaintiff disputes the validity of this proxy, arguing that there is no basis for equating the costs of NF-As with the costs of ADHCs. Reply at 12.

Plaintiffs, however, submit declarations from ADHC providers which, they argue, indicate that ADHC provider costs currently exceed the reimbursement rate of $76.22 per patient participant ("participant") per day, and that the five percent rate reduction will serve to exacerbate this disparity. Mot. at 18; *see* Kauffman Decl. ¶ 6 (costs are $97.48 per participant per day); Vega Decl. ¶ 10 (costs are $95 per participant per day; five percent rate reduction will increase daily per participant deficit from $18.78 to $22.59); Regalia Decl. ¶ 7 (costs are $102 per participant per day). Plaintiffs further submit evidence that many ADHCs have closed in recent years due to financial pressures. Mot. at 18; Puckett Decl. ¶ 5 (closure of ADHC site in 2007 due to failure of Medi-Cal reimbursement to keep pace with costs); Vega Decl. ¶ 6 (Orange County ADHC closed in 2007 due to unmet costs by Medi-Cal). Plaintiffs argue that the declarations of ADHC providers indicate that many more ADHCs may be forced to close as a result of the AB 1183 rate reductions. Puckett Decl. ¶ 12 (five percent cut "threatens the very existence of our program"); Vega Decl. ¶ 11 (changes in Medi-Cal reimbursement places ADHC in jeopardy of closing.); Kauffman Decl. ¶¶ 8-10; Nolcox Decl. ¶ 9. Other ADHCs, plaintiffs argue, would be forced to take on fewer participants, meaning that some unserved Medi-Cal beneficiaries may be forced to enter a nursing home. Puckett Decl. ¶ 11 (as a result of AB 1183 reductions, ADHC cannot provide participants with transportation and will have to delay admissions); Kauffman Decl. ¶ 9 (reimbursement rate

reductions will force ADHC to make additional cutbacks to services and staff); Davis Decl. ¶¶ 5-7. Furthermore, plaintiff argues that the rate reduction will force ADHC participants to receive care in higher cost settings, such as emergency rooms and skilled nursing facilities, and that, due to shortages in skilled nursing facilities, some participants will be forced into institutions far from their families. Mot. at 20; Missaelides Decl. ¶¶ 20-21; Kauffman Decl. ¶¶ 10-11; Puckett Decl. ¶ 12; Pl's RJN Ex. 6 (Legislative Analyst's Office Analysis of 2008-09 Budget) at C-39 ("if rate reductions force Adult Day Health Care Centers to close, beneficiaries who rely on services provided by the centers to stay in their homes may be forced to enter into relatively more costly nursing homes or other assisted living facilities"). Plaintiffs also argue that plaintiffs Charles Gallagher and Fe Garcia, who both attend ADHC's, would be irreparably harmed if their ADHCs were to close. Mot at 22-23; Gallagher Decl. ¶¶ 7-8; Garcia Decl. ¶¶ 2, 4.

The Court finds that the evidence submitted by plaintiffs indicate that Medi-Cal beneficiaries are at risk of losing access to ADHC services due to the AB 1183 rate reduction. Furthermore, the Court is not convinced that the Department's data comparing the number of Medi-Cal claims under AB 5 to the previous year demonstrates that the rate reductions will not affect access, given that this data reflects claims immediately after the AB 5 rate reductions were implemented, when the full effect of the rate reduction might not yet have been felt by ADHCs. *See*

Reply at 18. Therefore, the Court finds that plaintiffs have established sufficient irreparable harm so as to warrant an injunction.

### D. BALANCE OF HARDSHIPS

The Court is mindful of the difficulty facing the State of California in light of its fiscal crisis.[7] However, the State has accepted federal funds under the Medicaid Act. In so doing, the State agreed to abide by the conditions imposed by Congress. Further, retroactive relief for Medi-Cal beneficiaries will likely be inadequate and, and it will come too late, to remedy their pain, suffering, and harm to their mental and physical well-being. *See e.g., Lopez v. Heckler,* 713 F.2d 1432, 1437 (9th Cir. 1983). In light of the significant threat to the health of Medi-Cal recipients, reducing payments to health-care service providers will likely cause, and given that nothing in this Court's order prevents respondent from imposing a rate reduction after she has appropriately considered and applied the relevant factors, the Court finds that the balance of hardships tips in favor of granting the preliminary injunction.

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[7] Furthermore, if the five percent rate reduction is given effect, many Medi-Cal beneficiaries may turn to more costly forms of medical care, such as emergency room care, thereby diminishing the State's projected savings. *See e.g., Rodde v. Bonta,* 357 F.3d 988, 999 (9th Cir. 2004).

### E. PUBLIC INTEREST

"The district court's public interest analysis should be whether there exists some critical public interest that would be injured by the grant of preliminary relief." *Hybritech*, 849 F.2d at 1458. Clearly, there is a public interest in ensuring that the State has enough money to meet its financial obligations in the face of competing demands. However, there is also a public interest in ensuring access to health care. In light of all the circumstances, including the fact that the State may decide to implement a rate change upon making a properly reasoned and supported analysis, the Court finds that the public interest does not weigh against the issuance of a preliminary injunction.

## IV. CONCLUSION

For the foregoing reasons, the Court GRANTS plaintiffs' motion for preliminary injunction. The Court hereby orders respondent Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191, as modified by AB 1183 beginning on March 9, 2009, by refraining from reducing by five percent payments to ADHCs provided under the Medi-Cal fee-for-service program.

IT IS SO ORDERED.

Dated: March 9, 2009 /s/ Christina A. Snyder
CHRISTINA A. SNYDER
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

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| California Pharmacists Association, et al.<br><br>Plaintiffs,<br><br>vs.<br><br>David Maxwell Jolly<br><br>Defendant. | Case No.<br>CV 09-722 CAS (MANx)<br><br>**ORDER DENYING PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AS TO HOSPITALS**<br><br>(Filed Mar. 9, 2009) |

## I. INTRODUCTION AND BACKGROUND

On September 16, 2008, the California Legislature passed Assembly Bill 1183 ("AB 1183"), which was subsequently signed by the Governor and filed with the Secretary of State on September 30, 2008. AB 1183, *inter alia*, amends Cal. Welf. & Inst. Code. § 14105.191 and § 14166.245, mandating that, effective March 1, 2009, Medi-Cal reimbursement payments to some fee-for-service providers will be reduced by one percent, five percent, or ten percent, depending on provider type.

These reductions mandated in AB 1183 replace the ten percent rate reduction put into place by Assembly Bill X3 5 ("AB 5"), which terminated on February 28, 2009. *See* Cal. Welf. & Inst. Code § 14105.19(b)(1). AB 5 was passed by the California Legislature on February 16, 2008. On August 18,

2008, the ten percent rate reduction mandated by AB 5 was partially enjoined by this Court in a related action, *Independent Living Center of Southern California, Inc. v. Sandra Shewry*, CV-08-3315-CAS. In issuing the preliminary injunction, this Court found that petitioners had, *inter alia*, demonstrated a strong likelihood of success in showing that AB 5 was preempted by § 30(A) of the Medicaid Act (referred to herein as "§ 30(A)"). The Court enjoined the rate reduction as to physicians, dentists, pharmacies, adult day health care centers ("ADHCs"), and clinics. However, the Court did not enjoin the rate reduction as to non-contract hospitals, finding that plaintiffs had not presented sufficient evidence of irreparable harm to those providers. The Court's August 18, 2008 order is currently being appealed to the Court of Appeals for the Ninth Circuit.[1]

On January 29, 2009, plaintiffs California Pharmacists Association; California Medical Association; California Dental Association; California Hospital Association; California Association for Adult Day

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[1] The Court's August 18, 2008 order was issued on remand from the Ninth Circuit, after plaintiffs appealed this Court's original June 25, 2008 ruling on their preliminary injunction motion. The Court's June 25, 2008 order found that plaintiffs in *Independent Living* lacked any federal rights under § 30(A), and therefore had denied petitioners' motion for preliminary injunction. On appeal, the Ninth Circuit held that plaintiffs could bring suit under the Supremacy Clause to enjoin AB 5 as preempted under the Medicaid Act, and remanded to this Court. *See Independent Living Center of Southern California et. al. v. Sandra Shewry et al.*, 543 F.3d 1050 (9th Cir. 2008).

Services; Marin Apothecary, Inc.; South Sacramento Pharmacy; Farmacia Remedios, Inc.; Acacia Adult Day Services; Sharp Memorial Hospital; Grossmont Hospital Corporation; Sharp Chula Vista Medical Center; Sharp Coronado Hospital and Healthcare Center; Fey Garcia; and Charles Gallagher filed the instant action against David Maxwell-Jolly, Director of the Department of Health Care Services of the State of California. Plaintiffs' complaint challenges the AB 1183 Medi-Cal reimbursement rate reductions to various providers.

On February 11, 2009, plaintiffs filed the instant motion for a preliminary injunction. Plaintiffs seek an order for a preliminary injunction restraining and enjoining the defendant from reducing Medi-Cal fee-for-service rates to hospitals pursuant to Assembly Bill 1183. Defendant filed an opposition thereto on February 26, 2009. A reply was filed on March 4, 2009. After carefully considering the arguments set forth by the parties, the Court finds and concludes as follows.

## II. HOSPITAL REIMBURSEMENT BEFORE AND AFTER AB 1183

In their motion, plaintiffs distinguish between four distinct types of hospital services, for which Medi-Cal reimbursement rates are determined in different ways: (1) inpatient services, (2) outpatient services, (3) Distinct Part Nursing Facilities ("DP/NF's"), and (4) subacute services.

The reimbursement rates for inpatient services at issue in this motion are those provided to a specific type of hospital, known as a "non-contract hospitals." In 1982, the California Legislature authorized the Department to enter into contracts with certain hospitals for inpatient services, under the selective provider contracting program ("SPCP"). Mot at 3; *See* Cal. Welf Inst. Code §§ 14081 *et seq*. Hospitals with SPCP contracts are referred to as "contract hospitals" and are generally reimbursed for Medi-Cal at per diem rates, which are negotiated by the California Medical Assistance Commission ("CMAC"). Mot. at 3; Opp'n at 7; Chell Decl. ¶¶ 3, 5. Reimbursement rates to contract hospitals are not affected by AB 1183. By contrast, non-contract hospitals operating outside of a geographic area where a contract hospital exists are reimbursed for inpatient services to Medi-Cal patients, at a rate equaling the lowest of (1) its customary charge, (2) its reasonable costs determined using Medicare principles, (3) an all-inclusive rate per discharge determined by computing a base year cost per discharge and then limiting annually increases to the base rate, or (4) the 60th percentile rate per discharge of the hospitals in its "peer group."[2] [3] Mot. at 3; Opp'n at 8.

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[2] By contrast, where non-contract hospitals are located in the same geographic area (known as a Health Facility Planning Area) where contract hospitals are providing adequate services to the area's populations, the hospitals not covered by a contract will be reimbursed only in emergency situations.

[3] Defendant note that non-contract hospitals may also receive supplemental MediCal reimbursements under programs such as the disproportionate share hospital (DSH) program, the

(Continued on following page)

For outpatient services as opposed to inpatient services, hospitals are reimbursed at established rates set by the Department. Mot. at 4; 22 CCR § 51509. For DP/NF's, Medi-Cal reimbursement is determined by a prospectively established per diem reimbursement rate for daily services, which is the lesser of a facility's projected costs or a prospectively determined median per diem rate. Mot. at 4; 22 CCR § 51511(a)(2). For subacute services, facilities are reimbursed per diem at a rate equal to the lesser of the facility's per day costs as projected by the Department or the class median per diem rate established by the Department. Mot. at 5; 22 CCR § 51511.5(a)(1).

For inpatient services at non-contract hospitals, AB 1183 amends Cal. Welf. & Inst. Code § 14166.245 to retain AB 5's ten percent reduction to both interim and final payment rates, and to mandate that such reimbursement be limited to "the applicable regional per diem contract rate for tertiary hospitals and for all other hospitals . . . Reduced by 5%, multiplied by the number of Medi-Cal covered inpatient days . . . ["the CMAC limit"]" Cal. Welf. & Inst. Code 14166.245(b)(2)(A), (c)(3)(B).[4] For DP/NF and subacute services, AB 1183 mandates a five percent reduction (from pre-AB 5 rates) in reimbursement rates. Cal.

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Safety Net Care Pool (SNCP) program, and the Health Care Coverage Initiative (HCCI) program. Opp'n at 8; Amended Department Inpatient Analysis at 12.

[4] Certain hospitals, including small and rural hospitals, are exempt.

Welf. & Inst. Code § 14105.191. AB 1183 also mandates a one percent reimbursement rate reduction (from pre-AB 5 rates) for outpatient services. Cal. Welf. & Inst. Code § 14105.191.

## III. LEGAL STANDARD

A preliminary injunction is appropriate when the moving party shows either (1) a combination of probable success on the merits and the possibility of irreparable harm, or (2) the existence of serious questions going to the merits and that the balance of hardships tips sharply in the moving party's favor. *See Rodeo Collection, Ltd. v. West Seventh*, 812 F.2d 1215, 1217 (9th Cir. 1987). These are not two distinct tests, but rather "the opposite ends of a single 'continuum in which the required showing of harm varies inversely with the required showing of meritoriousness.'" *Id.* A "serious question" is one on which the movant "has a fair chance of success on the merits." *Sierra On-Line, Inc. v. Phoenix Software, Inc.*, 739 F.2d 1415, 1421 (9th Cir. 1984).

## IV. DISCUSSION

### A. LIKELIHOOD OF SUCCESS ON THE MERITS

Pursuant to the holding of the Ninth Circuit in the related action *Independent Living*, 543 F.3d at 1065, the Court finds, as an initial matter, that plaintiffs may pursue a claim for relief under the Supremacy Clause based on the allegation that AB

1183 is preempted by § 30(A). Here, plaintiffs' Supremacy Clause claim is predicated upon federal conflict preemption. Under general principles of federal preemption, state law is preempted only to the extent that it actually conflicts with federal law. *Pacific Gas & Elec. Co. v. State Energy Comm'n*, 461 U.S. 190, 204 (1983). Such a conflict may arise either where "compliance with both federal and state regulations is a physical impossibility, or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id.* at 203-04 (citations omitted).

Thus, to prevail on the merits plaintiffs will have to prove either that it is not possible for the Department to comply with both AB 1183 and the Medicaid Act or that AB 1183 stands as an obstacle to the enforcement of § 30(A). As such, the Court turns to the statutory provisions at issue here.

The "quality of care" provision of § (30)(A) provides that:

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care.

42 U.S.C. § 1396a(30)(A). The "equal access" provision of § 30(A) provides that:

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

*Id.*

In *Orthopaedic Hospital v. Kizer*, 1992 WL 345652 (C.D. Cal. 1992) ("*Orthopaedic I*"), plaintiff-hospital providers filed suit pursuant to 42 U.S.C. § 1983 ("§ 1983"), claiming that the Director violated § 30(A) by setting reimbursement rates for hospital outpatient services without considering the effect of hospital costs on efficiency, economy, and quality of care.[4] *Id.* at *1. The district court concluded that § 30(A) was enforceable in a § 1983 action, and that the Department "had a judicially enforceable obligation" to consider and make findings each time it

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[4] The hospitals did not, however, challenge the rates under the "equal access" provision. *Orthopaedic I*, 1992 WL 345652 at *14 n.4.

modified reimbursement rates. *Id.* at *2. According to the district court, § 30(A) obligated the Department to consider efficiency, economy, and quality of care, which it referred to as the "relevant factors." *Id.* at *4. The district court found that the Director had acted arbitrarily and capriciously in establishing six of the seven challenged rates. *Id.* The court then remanded the matter to the Department for further consideration. *Id.* at *14. Upon remand, the Department conducted a rate study, and readopted the reimbursement rates without change. *Orthopaedic Hospital II/III,* 103 F.3d 1491, 1495 (9th Cir. 1997).

The hospitals returned to the district court, filing two lawsuits (*Orthopaedic II/III* ) that the district court consolidated, arguing that the adopted rates did not comply with § 30(A). *Id.* The district court entered judgment in favor of the Department, finding that the Department was not statutorily required to consider hospital costs when setting reimbursement rates. *Id.* The hospitals appealed, and the Ninth Circuit reversed. The Ninth Circuit's interpretation held that § 30(A) "provides that payments for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Id.* at 1496 (emphasis in original). The Ninth Circuit therefore concluded that under § 30(A)

> the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services,

> unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

*Id.*[6] Further, the Ninth Circuit found that "[i]t is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons." *Id.* at 1499 n.3.[7]

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[6] *See e.g., Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-41 (9th Cir. 2005); *see also Arkansas Med. Soc'y v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) ("We agree with the trial court's conclusion that the relevant factors that DHS is obliged to consider in its rate-making decisions are the factors outlined in 42 U.S.C. § 1396a(a)(30)(A)."); *cf. Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding that § 30(A) does not require a state to consider any particular factors, but rather, requires that the state arrive at substantive results consistent with the Medicaid Act); *Rite Aid, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999) (same).

[7] Subsequently, in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), the Ninth Circuit held that § 30(A) does not confer individual rights that are enforceable under 42 U.S.C. § 1983. *Id.* at 1060. However, in *Independent Living*, 543 F.3d 1050 (9th Cir. 2008), the Ninth Circuit held that "a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right,' in the sense that term has been recently used in suits brought under § 1983, but need only satisfy traditional standing requirements." *Independent Living*, 543 F.3d 1050, 1058 (9th Cir. 2008).

Whatever else its effect may have been, it is clear that *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005) left undisturbed the rule announced in *Orthopaedic II/III* that § 30(A) creates duties on behalf of the Department, i.e., the duty to consider efficiency, economy, and quality of care when establishing reimbursement rates. Indeed, the *Sanchez* court recognized that "[§ 30(A) ] speaks . . . of the *State's obligation* to develop 'methods and procedures' for providing services generally." *Sanchez*, 416 F.3d at 1059 (emphasis added).

Because *Orthopaedic II/III* is binding authority on this Court, the Court finds that when the State of California seeks to modify reimbursement rates for health care services provided under the Medi-Cal program, it must consider efficiency, economy, and quality of care, as well as the effect of providers' costs on those relevant statutory factors.

In the instant motion for preliminary injunction, plaintiffs argue that AB 1183's rate reductions to hospitals is preempted by § 30(A), because the Legislature did not consider any of the relevant factors as required by *Orthopaedic II/III*. Specifically, plaintiffs argue that the legislative history indicates that "the California Legislature did not undertake studies of hospital costs prior to enacting AB 1183, or give any consideration to whether the payment rates which would be in effect under the application of the AB 1183 Hospital Rate Cuts would be reasonably related to hospital costs." Mot. at 13. Furthermore, plaintiffs argue that the language of AB 1183 itself

indicates that it was passed purely for budgetary reasons. For example, Cal. Welf. & Ins. [sic] Code § 14166.245, the provision implementing reductions to inpatient hospital services, states

> The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

Defendants, however, argue that the requirements of *Orthopaedic II/III* are in fact satisfied, because the Department itself performed a detailed analysis of the relevant factors. Specifically, defendant argues that beginning in October 2008 and continuing into February 2009, the Department conducted formal written analyses of reimbursement under AB 1183 for non-contract hospital inpatient services, DP/NF, and subacute services, which are contained in the reports entitled "[Amended] Analysis of the Impact of Welfare and Institutions Code Section 14166.245 Concerning Medi-Cal Reimbursement for Non-Contract Hospital Inpatient Services" ("Amended Department Inpatient Analysis") and "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement For Various Nursing Facility Services" ("Department Nursing Analysis").

Plaintiffs, however, argue that the Department's post-hoc analysis does not satisfy the requirements of

*Orthopaedic II/III*. The Court agrees. First, the Court notes that AB 1183, as passed by the Legislature, does not provide the Department with any discretion to determine whether the five percent rate reduction should be implemented based on the Department's consideration of the relevant factors. *See* Cal. Welf. & Inst. Code. § 14105.191 ("Notwithstanding any other provision of law, or order to implement changes in the level of funding for health care services, the *director shall reduce* provider payments, as specified in this section . . . ") (emphasis added). In *Orthopaedic II/III*, in which rates set by the Department, rather than the Legislature, were at issue, the court stated that the "the Department must rely on responsible cost studies, its own or others', that provide reliable data *as a basis* for its rate setting." 103 F.3d at 1496 (emphasis added); *see also id.* at 1499-1500 ("Since the Department did not adequately consider hospitals' costs *when readopting its rates*, the Department's actions were arbitrary and capricious and contrary to law") (emphasis added). The *Orthopaedic II/III* holding therefore indicates that the body responsible for rate setting must consider the relevant factors contemporaneously with the adoption of the rates. Because the Department has no authority to alter the rate reduction imposed by the Legislature, the Department's post hoc analysis does not satisfy the requirements of *Orthopaedic II/III*.

Furthermore, in this case, it does not appear that the Legislature appropriately considered any of the relevant factors before passing AB 1183.[4] Defendant responds to plaintiffs' arguments that the Legislature did not perform the required analysis by submitting evidence indicating that (1) between May 2008 and September 2008, Department employees provided information to legislative staff members concerning the rate reductions; (2) in June 2008, the Subcommittee 3 Health Human Services, Labor, and Veterans Affairs Major Action Report included modifications and rejections of certain rate reductions proposed by the Administration; and (3) in July 2008, the Summary Overview Budget Conference Committee Report includes discussions of the rate reductions. *See* Trueworthy Decl. ¶ 5, Exs. A-E. However, none of this evidence demonstrates that the Legislature relied on responsible cost studies providing

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[4] Defendant argues that "the Legislature followed the advice of the Legislative Analyst Office's (LAO) report concerning the 2008-2009 Budget . . . While the LAO expressed concerns about reductions for physician services, the LAO stated that 'Hospitals and some other providers have received recent rate increases. In contrast to physicians, Medi-Cal adjusts on an annual basis the reimbursement rates for certain other providers.'" Opp'n at 1. While defendant is correct that the LAO report discussed the possible rate reduction for hospital services, and ultimately concluded that such reductions were advisable, defendant presents no evidence to indicate that the Legislature actually reviewed or considered the LAO's report in passing AB 1183.

reliable data in setting the rates. *See Orthopaedic Hospital II/III*, 103 F.3d at 1496.

Therefore, because it appears that the Legislature and the Department did not properly consider the relevant factors prior to passing the rate reductions in AB 1183, the Court finds that plaintiffs have a strong likelihood of success on the merits.[9]

## B. IRREPARABLE HARM

The next question before this Court is whether plaintiffs have shown that Medi-Cal beneficiaries will be irreparably harmed if the rate reduction to hospitals is permitted to go into effect. First, plaintiffs argue that the rates under AB 1183 are not reasonably related to provider costs. Mot. at 11. With regard to inpatient services, plaintiffs' submit an analysis of the effect of the AB 1183 ten percent rate reduction, which finds that, under AB 1183, no non-contract hospital will receive more than 90 percent of costs for inpatient services, while one-third of the hospitals will receive less than 55 percent of their

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[9] Plaintiffs also argue that (1) AB 1183 is preempted by § 13(A) of the Medicaid Act, because the State failed to comply with that provision's notice-and-comment requirements, and (2) AB 1183 violates 42 C.F.R. §§ 430.12, 447.252, 447.256(a)(1) because it was implemented without approval from the Federal government. Because the Court finds herein that plaintiffs have established a strong likelihood of success in demonstrating that the AB 1183 rate reductions for hospitals are preempted by § 30(A), the Court need not reach these issues.

costs for inpatient services. Mot. at 11; Zaretsky Decl. Ex. D (Comparison of Medi-Cal Percentages of Costs Paid Under 2009 Payment Limit and Under Prior, Cost Reimbursement, System); Ex E (Frequency Distribution of the Medi-Cal Percentages of Cost Paid Under the 2008 Reimbursement Limit and Under the Cost Reimbursement System). By contrast, plaintiffs argue, prior to AB 5 and AB 1183, 87 of the 95 affected hospitals were reimbursed between 95 and 100 percent of their costs for inpatient services. *Id.* Furthermore, plaintiffs argue, the CMAC limit imposed by AB 1183 does not take into account variations among hospitals in their costs in setting reimbursement, and, therefore, the reimbursement rates do not take [sic] reflect the costs of the individual hospital. Mot. at 12-13.

With regard to DP/NF services, which are reimbursed based on the lower of the projected costs or a statewide "median" cost per diem, and are subject to a five percent rate reduction under AB 1183, plaintiffs argue that the median cost per diem excludes certain DP/NF's with high costs, and that, as a result, the median is artificially deflated. Plaintiffs argue that while before AB 5 and AB 1183, 84 percent of costs of DP/NF services were reimbursed, under AB 1183, only 79 percent of costs will be reimbursed, and many facilities will receive less than half of their costs. Mot. at 14; Zaretsky Decl. ¶ 23.

With regard to subacute services, which are also subject to a five percent rate reduction under AB 1183, plaintiffs argue that the percentage of reimbursed

costs will decrease from 98 percent (before AB 5 and AB 1183) to 93 percent of costs for non-ventilator service providers, and from 95 percent (before AB 5 and AB 1183) to 91 percent of costs for ventilator services providers. Zaretsky Decl. ¶ 25.

With regard to hospital outpatient services, which are subject to a one percent rate reduction under AB 1183, plaintiffs argue that reimbursement for costs will decrease from 43 percent of costs (before AB 5 and AB 1183) to 41 percent of costs. Mot. at 14; Zaretsky Decl. ¶ 21.

Plaintiffs next argue that these rate reductions will cause irreparable harm, in the form of reduced hospital services to Medi-Cal beneficiaries. Plaintiffs argue first that many hospitals have already eliminated services due to the AB 5 rate cuts, which has in turn impacted the availability of medical services in certain communities. Duaner Decl. ¶ 8; Jordan Decl. ¶ 6; Miller ¶ 4; DeNio ¶ 4. Plaintiffs argue that AB 1183 will render inevitable further reductions and elimination of some hospital services. McKague Decl. ¶ 6; Delmore Decl. ¶ 6; Riccioni ¶¶ 4-5. For example, plaintiffs argue that the rate cuts will likely result in the forced closure of (1) the emergency department at Central Valley General Hospital in Hanford, CA; (2) skilled nursing and subacute units at Sharp Coronado Hospital and Healthcare Center; and (3) the Diabetes Education Center and Children's Speciality Clinic at El Centro Regional Medical Center in El Centro California (forcing patients to travel two hours to San Diego to obtain these

services).[10] Mot. at 21-22; McKague Decl. ¶ 6; Hall Decl. ¶¶ 5-7; Farmer Decl. ¶¶ 7-8.

Defendant, however, argues that the showing of harm by plaintiffs is too speculative. With regard to inpatient services, defendant argues that the Amended Department Inpatient Analysis determined that Medi-Cal reimbursement for noncontract hospital inpatient services will compensate approximately 91 percent of hospitals' audited costs under AB 1183; if small and rural hospitals, which are exempt from the rate reduction, are excluded from the analysis, 86 percent of hospitals' audited costs will continue to be reimbursed under AB 1183. Opp'n at 9; Amended Department Inpatient Analysis at 13. With regard to DP/NF and subacute services, defendant argues that under AB 1183, DP/NF and subacute providers will be reimbursed within a "range of reasonableness" (i.e. 85-95 percent of costs), and that the Department Nursing Analysis indicates that there will be

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[10] Plaintiffs also argue that hospitals will suffer pecuniary harm, and that such harm is irreparable because retroactive monetary claims are barred by the Eleventh Amendment in this action. Mot. at 22, citing *Kansas Health Care Assoc. v. Kansas Dept. Of Social and Rehabilitation Svcs.*, 31 F.3d 1536, 1543 (10th Cir. 1994) (harm from inadequate Medicaid reimbursement rates would be irreparable because Eleventh Amendment bars retrospective monetary relief). However, the Court notes that in that case, the Court held "the Eleventh Amendment bar simply indicates irreparability, but does not, in itself, establish harm." *See id.*

sufficient access to these services.[11] Opp'n at 10-11; Yien Decl. ¶ 4, 8. In addition, defendant notes that the transition from AB 5 to AB 1183 will in fact increase by 5.5 percent the reimbursement for these types of services. Opp'n at 11; Yien Decl. ¶¶ 2-18. Similarly, with regard to outpatient services, defendant notes that under AB 5 there was a ten percent rate reduction in effect, which is decreased to one percent under AB 1183. Opp'n at 11.

Defendants also argue that plaintiffs' evidence does not take into account the fact that Medi-Cal pays substantial supplemental reimbursement to many non-contract hospitals, which is not affected by AB 1183. Opp'n at 14; Liu Decl. ¶ 18. In fact, defendant argues that several of the hospitals submitting declarations in support of the preliminary injunction receive substantial additional reimbursement under one of the supplemental reimbursement programs not impacted by AB 1183, and that, additionally, many of the hospitals submitting declarations are making large profits.[12] Hutchinson Decl. ¶¶ 1-18 (describing various supplemental reimbursement programs paying extra money to hospitals including some submitting

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[11] Plaintiffs argue that the disparity between plaintiffs' cost estimate (reimbursement at 79 percent of costs) and defendant's cost estimate is that defendant included in the analysis supplemental payments, which were only received by 13 of the 78 hospitals included in the analysis. Reply at 15-16.

[12] Plaintiffs, however, respond that many of the supplemental reimbursement programs provide funding for services to non-MediCal patients. Reply at 13.

declarations); Ong Decl. ¶ 17 (14 of 19 hospitals submitting declarations were profitable in fiscal year ending in 2007, having a collective net income of $181.3 million; five hospitals operating at a loss, with a collective net loss of $29.2 million). Furthermore, defendant notes that reimbursement for hospital outpatient services has significantly increased between 2001 to 2004 to 43 percent above the levels in effect three years earlier. Opp'n at 12; Machado Decl. ¶ 9.

The Court agrees with defendant that plaintiffs have failed to show that AB 1183 rate reductions to hospitals will result in irreparable harm so as to warrant the issuance of an injunction. First, the Court notes that the Legislative Analyst Office's Report on the 2008-09 budget specifically recommended that the Legislature accept the Governor's proposal to reduce Medi-Cal reimbursement rates to hospitals, and indeed suggested that the Legislature increase the proposed reductions for hospitals. Legislative Analyst's Office Report, 2008-09 Analysis ("LAO Report") at C-39. The LAO report concluded ("[w]e recommend the Legislature reject the Governor's proposal to reduce payments for all providers except hospitals . . . Our review indicates that hospitals have received significant rate increases relative to other provider types in recent years, and hospitals are generally among the most expensive settings to provide care"). LAO Report at C-39.

More importantly, there is evidence showing that approximately 90 percent of hospital inpatient services are provided by contract hospitals that are

not subject to the AB 1183 rate reductions, and that such hospitals are contractually obligated to provide inpatients services to all Medi-Cal beneficiaries for whom such services are medically necessary and covered by Medi-Cal. *See* Amended Department Inpatient Analysis at 14. Moreover, there is evidence that there are 87 Federally Qualified Health Centers ("FQHC's") and 284 Rural Health Clinics ("RHC's") throughout California that provide outpatient services, which are not subject to the AB 1183 rate reduction. Opp'n at 12; Shine Decl. ¶ 4. Therefore, although there may be certain limited exceptions, it appears unlikely that Medi-Cal beneficiaries will go without access to needed inpatient and outpatient services under the AB 1183 rate reductions. Furthermore, defendant has submitted evidence demonstrating that many of the hospitals submitting declarations were profitable in the fiscal year ending in 2007, indicating that these facilities are likely capable of continuing to provide services even with the rate reductions in effect. Ong Decl. ¶ 17. Based on the present record, this evidence presented is too speculative to support a finding of irreparable harm.[13]

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[13] Because the Court finds herein that plaintiffs have failed to show irreparable harm, the Court determines that, regardless of the Court's findings regarding the balance of hardships and the public interest, a preliminary injunction is not warranted.

## V. CONCLUSION

For the foregoing reasons, the Court DENIES plaintiffs' motion for preliminary injunction with regard to AB 1183's reimbursement rate reduction to hospitals, without prejudice to its being renewed after the Ninth Circuit rules on the appeal in *Independent Living Center of Southern California, Inc. v. Sandra Shewry*, CV-08-3315-CAS.

IT IS SO ORDERED

Dated: March 9, 2009

/s/ Christina A. Snyder
CHRISTINA A. SNYDER
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

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| Managed Pharmacy Care, et al.<br><br>Plaintiff(s),<br><br>vs.<br><br>David Maxwell Jolly<br><br>Defendant(s). | Case No. CV 09-382 CAS (MANx)<br><br>ORDER GRANTING PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION<br><br>(Filed Feb. 27, 2009) |

## I. INTRODUCTION AND BACKGROUND

On September 16, 2008, the California Legislature passed Assembly Bill 1183 ("AB 1183"), which was subsequently signed by the Governor and filed with the Secretary of State on September 30, 2008. AB 1183 amends Cal. Welf. & Inst. Code. § 14105.19 and mandates that, effective March 1, 2009, Medi-Cal reimbursement payments to some fee-for-service providers will be reduced by one percent or five percent, depending on provider type. Particularly relevant to the instant action, AB 1183 enacts a modified Cal. Welf. Inst. Code § 14105.191(b)(3) so as to require that Medi-Cal fee-for-service payments to pharmacies be reduced by 5 percent.

These reductions mandated in AB 1183 replace the ten percent rate reduction put into place by Assembly Bill X3 5 ("AB 5"), which is scheduled to terminate on February 28, 2009. *See* Cal. Welf. & Inst.

Code § 14105.19(b)(1). AB 5 was passed by the California Legislature on February 16, 2008. On August 18, 2008, the ten percent rate reduction mandated by AB 5 was partially enjoined by this Court in a related action, *Independent Living Center of Southern California, Inc. v. Sandra Shewry,* CV-08-3315 CAS (MANx). In issuing the preliminary injunction, this Court found that petitioners had, *inter alia,* demonstrated a strong likelihood of success in showing that AB 5 was preempted by § 30(A) of the Medicaid Act (referred to herein as "§ 30(A)"). The Court's August 18, 2008 order is currently being appealed to the Court of Appeals for the Ninth Circuit.[1]

On January 16, 2009, Managed Pharmacy Care, Independent Living Center of Southern California, Inc., Gerald Shapiro, Sharon Steen, and Tran Pharmacy, Inc. filed the instant action against David Maxwell-Jolly, Director of the Department of Health Care Services of the State of California. Plaintiffs' complaint challenges the five percent Medi-Cal reimbursement rate reduction to providers of pharmacy

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[1] The Court's August 18, 2008 order was issued on remand from the Ninth Circuit, after plaintiffs appealed this Court's original June 25, 2008 ruling on their preliminary injunction motion. The Court's June 25, 2008 order found that plaintiffs in *Independent Living* lacked any federal rights under § 30(A), and therefore had denied petitioners' motion for preliminary injunction. On appeal, the Ninth Circuit held that plaintiffs could bring suit under the Supremacy Clause to enjoin AB 5 as preempted under the Medicaid Act, and remanded to this Court. *See Independent Living Center of Southern California et. al. v. Sandra Shewry et al.*, 543 F.3d 1050 (9th Cir. 2008).

services under AB 1183. Plaintiffs seek an order directing defendant "to set aside his preempted policy to implement § 14105.19 Welf. & Inst. Code, of AB 1183, and the 5% Rate Reduction, and, to refrain from implementing the same; including but not limited to refraining from reducing payments by five percent or by any other deduction, to pharmacy providers in the Medi-Cal FFS program, for services furnished on and after March 1, 2009."[2] Compl. at 8; Mot. at 1.

On February 2, 2009, plaintiffs filed the instant motion for a preliminary injunction. Defendant filed an opposition thereto on February 11, 2009. A reply was filed on February 16, 2009. Plaintiffs' motion for a preliminary injunction is currently before the Court.

## II. LEGAL STANDARD

A preliminary injunction is appropriate when the moving party shows either (1) a combination of probable success on the merits and the possibility of irreparable harm, or (2) the existence of serious questions going to the merits and that the balance of hardships tips sharply in the moving party's favor. *See Rodeo Collection, Ltd. v. West Seventh*, 812 F.2d 1215, 1217 (9th Cir. 1987). These are not two distinct tests, but rather "the opposite ends of a single 'continuum in which the required showing of harm varies inversely with the required showing of meritoriousness.'" *Id.*

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[2] On January 26, 2009, plaintiff Managed Pharmacy Care was voluntarily dismissed as a plaintiff in this action.

A "serious question" is one on which the movant "has a fair chance of success on the merits." *Sierra On-Line, Inc. v. Phoenix Software, Inc.*, 739 F.2d 1415, 1421 (9th Cir. 1984).

## III. DISCUSSION

### A. ELEVENTH AMENDMENT AND PRUDENTIAL STANDING

Before addressing the merits of plaintiffs' argument for preliminary injunction, the Court must first address two arguments raised by defendant: (1) that plaintiffs' suit is barred by the Eleventh Amendment and (2) that plaintiffs lack standing. The Court finds that neither of these arguments is persuasive.

The essence of defendant's Eleventh Amendment argument is that plaintiffs' suit effectively amounts to a request for money damages to be paid out of the state treasury, in violation of the Eleventh Amendment. *See* Opp'n at 20 ("the primary purpose driving this lawsuit is to obtain funds from the State above the 5% payment reduction"), citing *Edelman v. Jordan*, 415 U.S. 651 ("Thus the rule has evolved that a suit by private parties seeking to impose a liability which must be paid from public funds in the state treasury is barred by the Eleventh Amendment"). However, the Court disagrees with defendant's characterization of plaintiffs' claim. Plaintiffs complaint does not seek money damages, but instead seeks only prospective injunctive relief – namely, an injunction preventing defendant from enforcing a state law that,

defendants argue, is preempted by the Medicaid Act. Such prospective injunctive relief against a state official is permissible under *Ex Parte Young*, 209 U.S. 123 (1908), even where such an injunction will have an effect on the state treasury. *See, e.g., Milliken v. Bradley*, 433 U.S. 267 (federal courts permitted "to enjoin state officials to conform their conduct to requirements of federal law, notwithstanding a direct and substantial impact on the state treasury").

Defendant also argues that plaintiffs lack prudential standing, because they are health care providers who have no "rights" under the federal law they seek to enforce. Opp'n at 22. The Court disagrees. In its September 17, 2008 order in the related action *Independent Living*, 543 F.3d at 1065, the Ninth Circuit determined that petitioners in that action had standing:

> Petitioners include independent pharmacies and health care providers participating in the State's Medi-Cal program that, according to their complaint, will be directly injured, by loss of gross income, when the ten-percent rate reduction takes effect. The Supreme Court repeatedly has recognized that such [direct economic] injuries establish the threshold requirements of Article III standing. Moreover, this injury is directly traceable to the Director's implementation of AB 5, and would certainly be redressed by a favorable decision of this court enjoining the ten-percent rate reduction.

As in *Independent Living*, plaintiffs in the instant action include independent pharmacies participating in the Medi-Cal program, and an independent living center which serves over 8,000 individuals with disabilities annually, 96 percent of whom are Medi-Cal beneficiaries, who, plaintiffs allege, would be directly injured by the five percent Medi-Cal reimbursement rate reduction. *See* Vescovo Decl. ¶ 5. Therefore, the Ninth Circuit's holding in *Independent Living*, 543 F.3d at 1065, with regard to standing applies in this case as well, and the Court finds defendant's argument that plaintiffs lack standing to be without merit.

### B. LIKELIHOOD OF SUCCESS ON THE MERITS

Pursuant to the holding of the Ninth Circuit in the related action *Independent Living*, 543 F.3d at 1065, the Court finds, as an initial matter, that plaintiffs may pursue a claim for relief under the Supremacy Clause based on the allegation that AB 1183 is preempted by § 30(A). Here, plaintiffs' Supremacy Clause claim is predicated upon federal conflict preemption. Under general principles of federal preemption, state law is preempted only to the extent that it actually conflicts with federal law. *Pacific Gas & Elec. Co. v. State Energy Comm'n*, 461 U.S. 190, 204 (1983). Such a conflict may arise either where "compliance with both federal and state regulations is a physical impossibility, or where state law stands as an obstacle to the accomplishment and execution of

the full purposes and objectives of Congress." *Id.* at 203-04 (citations omitted).

Thus, to prevail on the merits plaintiffs will have to prove either that it is not possible for the Department to comply with both AB 1183 and the Medicaid Act or that AB 1183 stands as an obstacle to the enforcement of § 30(A). As such, the Court turns to the statutory provisions at issue here.

The "quality of care" provision of § (30)(A) provides that

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care.

42 U.S.C. § 1396a(a)(30)(A). The "equal access" provision of § 30(A) provides that

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the

> extent that such care and services are available to the general population in the geographic area.

*Id.*

In *Orthopaedic Hospital v. Kizer*, 1992 WL 345652 (C.D. Cal. 1992) ("*Orthopaedic I*"), plaintiff-hospital providers filed suit pursuant to 42 U.S.C. § 1983 ("§ 1983"), claiming that the Director violated § 30(A) by setting reimbursement rates for hospital outpatient services without considering the effect of hospital costs on efficiency, economy, and quality of care.[3] *Id.* at *1. The district court concluded that § 30(A) was enforceable in a § 1983 action, and that the Department "had a judicially enforceable obligation" to consider and make findings each time it modified reimbursement rates. *Id.* at *2. According to the district court, § 30(A) obligated the Department to consider efficiency, economy, and quality of care, which it referred to as the "relevant factors." *Id.* at *4. The district court found that the Director had acted arbitrarily and capriciously in establishing six of the seven challenged rates. *Id.* The court then remanded the matter to the Department for further consideration. *Id.* at *14. Upon remand, the Department conducted a rate study, and readopted the

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[3] The hospitals did not, however, challenge the rates under the "equal access" provision. *Orthopaedic I*, 1992 WL 345652 at *14 n.4.

reimbursement rates without change. *Orthopaedic Hospital*, 103 F.3d at 1495.

The hospitals returned to the district court, filing two lawsuits (*Orthopaedic II/III*) that the district court consolidated, arguing that the adopted rates did not comply with § 30(A). *Id.* The district court entered judgment in favor of the Department, finding that the Department was not statutorily required to consider hospital costs when setting reimbursement rates. *Id.* The hospitals appealed, and the Ninth Circuit reversed. The Ninth Circuit's interpretation held that § 30(A) "provides that payments for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Id.* at 1496 (emphasis in original). The Ninth Circuit therefore concluded that under § 30(A)

> the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

*Id.*[4] Further, the Ninth Circuit found that "[i]t is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons." *Id.* at 1499 n.3.[5]

Whatever else its effect may have been, it is clear that *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005) left undisturbed the rule announced in *Orthopaedic II/III* that § 30(A) creates duties on behalf of the Department, i.e., the duty to consider efficiency, economy, and quality of care when establishing reimbursement rates. Indeed, the *Sanchez* court recognized that "[§ 30(A)] speaks . . . of the

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[4] *See e.g., Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-41 (9th Cir. 2005); *see also Arkansas Med. Soc'y v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) ("We agree with the trial court's conclusion that the relevant factors that DHS is obliged to consider in its rate-making decisions are the factors outlined in 42 U.S.C. § 1396a(a)(30)(A)."); *cf. Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding that § 30(A) does not require a state to consider any particular factors, but rather, requires that the state arrive at substantive results consistent with the Medicaid Act); *Rite Aid, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999) (same).

[5] Subsequently, in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), the Ninth Circuit held that § 30(A) does not confer individual rights that are enforceable under 42 U.S.C. § 1983. *Id.* at 1060. However, in *Independent Living*, 543 F.3d 1050 (9th Cir. 2008), the Ninth Circuit held that "a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right,' in the sense that term has been recently used in suits brought under § 1983, but need only satisfy traditional standing requirements." *Independent Living*, 543 F.3d 1050, 1058 (9th Cir. 2008).

*State's obligation* to develop 'methods and procedures' for providing services generally."[6] *Sanchez*, 416 F.3d at 1059 (emphasis added).

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[6] Defendant nevertheless argues herein that under *Sanchez v. Johnson*, 416 F.3d 1051, plaintiffs are precluded from obtaining a judicial remedy, and that "Plaintiffs are attempting to have this Court undercut decades of federal jurisprudence to say that, merely by claiming to be suing under the Supremacy Clause instead of § 1983, a party can obtain a remedy in federal court against a state agency for non-compliance with a provision of the Medicaid Act . . . " Opp'n at 18. Defendant argues that the Ninth Circuit's holding in *Independent Living*, 543 F.3d 1050, does not contradict this argument, because the issue presented herein is substantially different from the issue presented in that case. Opp'n at 16 ("the only issue in front of the Court of Appeals in the *Independent Living Center* matter was 'whether ILC may maintain a valid cause of action to enjoin implementation of AB 5 on the basis of federal preemption"). However, the Court finds defendant's arguments unpersuasive. The Court disagrees that the issue presented herein is substantially different from the issue before the Ninth Circuit in *Independent Living*, 543 F.3d at 1063, and further notes that the Ninth Circuit in *Independent Living* specifically distinguished *Sanchez*:

> [In *Sanchez*] [w]e held that the quality of care and access provisions of § 30(A) do not give rise to the type of unambiguously conferred rights required under Gonzaga. But our decision in [*Sanchez*] had nothing to say about a claim for injunctive relief brought under the Supremacy Clause. Indeed, even as the Supreme Court has tightened the requirements for seeking damages under § 1983, it has consistently reaffirmed the availability of injunctive relief to prevent state officials from implementing state legislation allegedly preempted by federal law.

Defendant also argues herein that Congress has evinced an intent that § (30)(a) not be judicially enforced. Opp'n at 17, n.8. Specifically, defendant notes that the so-called "Boren

(Continued on following page)

Because *Orthopaedic II/III* is binding authority on this Court, the Court finds that when the State of California seeks to modify reimbursement rates for health care services provided under the Medi-Cal program, it must consider efficiency, economy, and quality of care, as well as the effect of providers' costs on those relevant statutory factors.

In the instant motion for preliminary injunction, plaintiffs argue that AB 1183's five percent

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Amendment," which required that states provide the Secretary with assurances that Medicaid reimbursements according to rates that were "reasonable and adequate" to meet costs, was repealed by Congress subsequent to a Supreme Court decision finding that providers had rights under the Boren Amendment to challenge the adequacy of a state's reimbursement rates under the Medicaid statute. Opp'n at 5. However, defendant's arguments are belied by *Orthopaedic II/III*, which held that the Department's obligations under § 30(a) were independent of the obligations imposed by the Boren Amendment:

> The Boren Amendment requires the Department to make assurances to the Secretary of Health and Human Services that rates are reasonable and adequate to meet the hospitals' costs, and requires periodic cost reports from hospitals subject to audit by the Department. These requirements are not part of § 1396a(a)(30)(A). The requirements of § 1396a(a)(30)(A) are more flexible than the Boren Amendment, but not so flexible as to allow the Department to ignore the costs of providing services. For payment rates to be consistent with efficiency, economy, quality of care and access, they must bear a reasonable relationship to provider costs, unless there is some justification for rates that do not substantially reimburse providers their costs.

*Orthopaedic II/III*, 103 F.3d at 1499.

reimbursement rate reduction to pharmacies is pre-empted by § 30(A), because the Legislature did not consider any of the relevant factors as required by *Orthopaedic II/III*. To demonstrate that the Legislature did not consider any of the relevant factors, plaintiffs first note that Sec. 76 of AB 1183 indicates that the purpose of the bill was budgetary:

> [t]his act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are: In order to make the necessary statutory changes to implement the Budget Act of 2008 at the earliest possible time, it is necessary that this act take effect immediately.

Plaintiffs further describe the legislative history of AB 1183, which, they argue, demonstrates that the Legislature did not consider any of the relevant factors:

> AB 1183 was introduced Feb. 2, 2008 as a hazardous material bill and was amended several times as solely a hazardous material bill. However, on September 15, 2008, the bill was amended in the Senate so as to be at once turned into a trailer bill, on many different subjects . . . All without any public hearings or any hearing by any committee of the Legislature; was passed shortly before midnight of the same day of September 15, 2008 by the Senate; was sent to the

> Assembly, and was immediately passed by the Assembly before 2:08 a.m. of September 16, 2008, – all within the space of a few hours . . .

Mot. at 8.

Defendant does not appear to contest that the Legislature did not in fact consider the relevant factors prior to passing AB 1183. However, defendant appears to argue that the requirements of *Orthopaedic II/III* are nevertheless satisfied, because the Department itself performed a detailed analysis of the relevant factors. Opp'n at 11. Specifically, defendant submits the Department's report "Analysis of Pharmacy Reimbursement under AB 1183," ("Department Analysis") completed in February 2009, well after the enactment of AB 1183 on September 16, 2008. Opp'n at 11. The Department Analysis analyzes the impact of the five percent rate reduction, and ultimately concludes:

> After a 5% payment reduction is implemented on March 1, 2009, Medi-Cal reimbursement paid to pharmacies will comply with title 42, United States Code, section 1396(a)(30)(A). The available data indicates that Medi-Cal recipients will continue to have sufficient access to pharmacy services as required by federal law. Reimbursement will be below applicable federal upper payment limits. The 5% payment reduction will result in more efficient and economical Medi-Cal coverage. It will not have any negative impact for Medi-Cal recipients. Finally, the Department

> determined that Medi-Cal reimbursement will in the aggregate compensate pharmacy drug costs at a level that is well above the "range of reasonableness" that was acceptable under the repealed Boren Amendment. Thus, reimbursement will be sufficient under the more flexible requirements of section 1396(a)(30)(A).

Def's Ex. A-A (Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Pharmacies) at 12-13. The Department Analysis further concludes that the Legislature "had other alternatives for reducing spending in the Medi-Cal program, which would have had a much more negative impact on Medi-Cal recipients. Def's Ex. A-A (Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Pharmacies) at 4.

Plaintiffs, however, argue that the Department's post-hoc analysis does not satisfy the requirements of *Orthopaedic II/III*. The Court agrees. First, the Court notes that AB 1183, as passed by the Legislature, does not provide the Department with any discretion to determine whether the five percent rate reduction should be implemented based on the Department's consideration of the relevant factors. *See* Mot. at 5-6; Cal. Welf. & Inst. Code. § 14105.191 ("Notwithstanding any other provision of law, or order to implement changes in the level of funding for health care services, the *director shall reduce* provider payments, as specified in this section . . . ") (emphasis added). In *Orthopaedic II/III*, in which rates set by the Department, rather than the Legislature, were at issue, the

court stated that the "the Department must rely on responsible cost studies, its own or others', that provide reliable data *as a basis* for its rate setting." 103 F.3d at 1496 (emphasis added); *see also id.* at 1499-1500 ("Since the Department did not adequately consider hospitals' costs *when readopting its rates*, the Department's actions were arbitrary and capricious and contrary to law") (emphasis added). The *Orthopaedic II/III* holding therefore indicates that the body responsible for rate setting must consider the relevant factors contemporaneously with the adoption of the rates. Here, the legislative history shows no indication that the Legislature considered any of the relevant factors before implementing AB 1183. Instead, it appears that the Legislature enacted the rate reduction purely for budgetary reasons. Because the Department has no authority to alter the rate reduction imposed by the Legislature, the Department's post hoc analysis does not satisfy the requirements of *Orthopaedic II/III*.

Therefore, because the Legislature did not consider any of the relevant factors prior to implementing the five percent rate reduction in AB 1183, the Court finds that plaintiffs have a strong likelihood of success on the merits.

### C. IRREPARABLE HARM

The next question before this Court is whether plaintiffs have shown that Medi-Cal beneficiaries will be irreparably harmed if the five percent rate

reduction to pharmacies is permitted to go into effect. After reviewing the declarations submitted by plaintiffs and defendant, the Court finds that plaintiffs have made a sufficient showing of irreparable harm to warrant an injunction.

Plaintiffs submit the declaration of Richard Wilson, a Certified Public Accountant who has examined various data regarding Medi-Cal prescription drug reimbursement – including the Survey of Dispensing and Acquisition Costs of Pharmaceuticals in the State of California, a December 2007 study prepared by Myers and Stauffer, CPA's ("Myers Stauffer study") – in order to examine the impact of the five percent rate reduction on pharmacies.

Wilson notes that there are two primary cost components in the provision of prescription drugs: dispensing cost and drug acquisition cost. Wilson states that the average cost to a pharmacy for dispensing a prescription is currently $11.49 per prescription, and that the five percent reimbursement rate reduction will reduce Medi-Cal coverage for pharmacies' dispensing fees, from an average of $7.25 per prescription to an average of $6.88 per prescription. Wilson Decl. ¶ 21-22. Wilson states that the five percent reduction will therefore increase the loss incurred by pharmacies on dispensing fees from $3.56 per Medi-Cal prescription to $4.61 per Medi-Cal prescription. Wilson Decl. ¶ 22.

Furthermore, Wilson, states that the five percent rate reduction will also cause pharmacies to

experience a loss on the acquisition of many brand and generic drugs. For example, Wilson states that the average acquisition costs for brand drugs is 79 percent of average wholesale price, while the amount of reimbursement that pharmacies will receive under the five percent rate reduction is only 78.85 percent of average wholesale price. Wilson Decl. ¶ 24. As a result, Wilson states that the five percent rate reduction will cause pharmacies to operate at a loss in the acquisition of 51 percent of the 200 top-selling brand drugs, and that pharmacies will make only a very small gross profit on an additional 12.5 percent of the top-selling brand drugs, a profit which will generally be insufficient to compensate for the loss that the pharmacies incur in dispensing costs. Wilson Decl. ¶ 25. With regard to generic drugs, Wilson states that the five percent rate reduction will cause pharmacies to operate at a loss or obtain only a very small gross profit on 39 percent of the top-selling generic drugs. Wilson Decl. ¶ 31.

Wilson concludes that because pharmacies, on average, will suffer a financial loss to acquire and dispense brand drugs as a result of the five percent rate reduction, many will be forced to stop dispensing many if not most brand products to Medi-Cal patients. Wilson Decl. ¶ 28. Wilson further concludes that, as a result of the five percent rate reduction, many pharmacies will also be forced to stop dispensing many of the generic drugs to Medi-Cal patients. Wilson Decl. ¶ 32.

Petitioners also submit additional declarations providing further evidence to the effect that the five percent rate reduction will cause independent pharmacy owners to limit the scope of the services they provide to Medi-Cal beneficiaries. Specifically, plaintiffs submit the declarations of ten independent pharmacists, many of whom state that the five percent rate reduction will significantly affect their ability to provide services to Medi-Cal patients. *See* Davis Decl. ¶ 8; Dunckel Decl. ¶ 8; Faast Decl. ¶ 8. For example, the pharmacists' declarations state that the total reimbursement under AB 1183 will cover neither their acquisition costs nor their dispensing costs on many drugs, and that, as a result, they will not be able to fill all Medi-Cal prescriptions, including some prescriptions for AIDS medications and name-brand antipsychotropics, and will not be able to serve all existing Medi-Cal customers. *See* Davis Decl. ¶ 8, 11; Dunckel Decl. ¶ 8, 11; Faast Decl. ¶ 11; Shapiro Decl. ¶ 26; Tran Decl. ¶ 17; Medina Decl. ¶ 11; Tran Decl. ¶ 20. Some of the pharmacists also state that the five percent rate reduction will prevent them from accepting new Medi-Cal patients. *See* Dunckel Decl. ¶ 11; Jeha Decl. ¶ 11. In addition, some pharmacists say they will be forced to cut the business hours of the pharmacy and lay off employees in order to remain profitable, while others state that the five percent rate reduction will force them out of business. *See, e.g.*, Jeha Decl. ¶ 11; Leonelli Decl. ¶ 11. Some pharmacists state that the five percent rate reduction will prevent them from providing prescription delivery service to their Medi-Cal beneficiary patients who

are unable to leave their homes. *See* Medina Decl. ¶ 9; Shapiro Decl. ¶ 26.

Defendant counters that plaintiffs' showing of harm is speculative and that, in fact, under the five percent rate reduction, "an extremely high percentage of pharmacy costs will be compensated and the more efficient pharmacies should be able to obtain a substantial profit from providing services under the Medi-Cal program." Opp'n at 5. For example, defendant notes that the Department Analysis estimates that under the five percent rate reduction, pharmacies will continue, on average, to be compensated above their costs for Medi-Cal prescriptions. *See* Def's Ex. A-A at 8 (stating that the five percent rate reduction will reduce the aggregate Medi-Cal reimbursement for prescription drugs from compensating approximately 108.7 percent of pharmacy costs to approximately 103 percent of pharmacy costs).

Defendant also submits the declaration of Kevin Gorospe, who is employed as the Department's Chief of Medi-Cal Pharmacy Policy Branch. Gorospe states that he has examined plaintiffs' submitted declarations, and has calculated that, with one exception, the total revenue loss after the five percent rate reduction for each pharmacist submitting a declaration in support of plaintiffs' motion will be less than 2 percent. Gorospe Decl. ¶ 12. Gorospe further argues that some of plaintiffs' cost estimates are misleading, because much of the average dispensing fee costs are costs of operation that a pharmacy incurs regardless of whether it provides drugs to Medi-Cal recipients, so

that "continued participation in Medi-Cal by these pharmacies brings in additional reimbursement that will help to pay for many of the costs of operating a pharmacy that the pharmacy would incur even if [it] didn't participate in Medi-Cal." Gorospe Decl. ¶ 13. Gorospe further echoes the Department Analysis, stating that dispensing cost increases will not cause irreparable harm, because "Medi-Cal reimbursement for the drug itself frequently is well above pharmacy acquisition cost, that any loss on the dispensing fee portion of reimbursement is made up for by a significant profit on MediCal reimbursement for the drug itself." Gorospe Decl. ¶ 21.

The Court concludes that defendant has failed to refute plaintiffs' showing of irreparable harm. Even if defendant is correct that, on average, pharmacies will be compensated above their acquisition costs even after the five percent rate reduction, defendant has not refuted plaintiffs' findings that many brand and generic drugs will be reimbursed at a level below cost, thereby preventing pharmacies from providing those drugs and limiting access for Medi-Cal patients. Indeed, the Gorospe declaration confirms that only 98-99 percent, on average, of pharmacy costs for single source drugs will be compensated after the five percent rate reduction. Because many single source drugs are protected from competition by patents, there are no available generic alternatives. *See* August 18, 2008 Preliminary Injunction Order. There can be little or no doubt that Medi-Cal patients will

be harmed if these necessary drugs are placed outside of their reach.

Furthermore, if pharmacists are forced to curtail services or go out of business, there is no indication that all existing customers will have access to other pharmacies in which to obtain their medication and, in some cases, home-delivery services for such medication. Indeed, the many declarations submitted by petitioners show that independent pharmacy providers, who constitute approximately thirty-three percent of the licensed community pharmacies in California, will be hard-hit by the five percent rate reduction, and may discontinue, or at least severely reduce, services to Medi-Cal beneficiaries. *See* August 18, 2008 Preliminary Injunction Order. Therefore, the Court concludes that plaintiffs have demonstrates [sic] a significant likelihood of irreparable harm.

## D. BALANCE OF HARDSHIPS

The Court is mindful of the difficulty facing the State of California in light of its fiscal crisis.[7] However, the State has accepted federal funds under the Medicaid Act. In so doing, the State agreed to abide by the conditions imposed by Congress. Further,

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[7] The Court notes that there is evidence to suggest that if the five percent rate reduction is given effect, many Medi-Cal beneficiaries will turn to more costly forms of medical care, such as emergency room care, thereby diminishing the State's projected savings. *See e.g., Rodde v. Bonta*, 357 F.3d 988, 999 (9th Cir. 2004).

retroactive relief for Medi-Cal beneficiaries will likely be inadequate and, and [sic] it will come too late, to remedy their pain, suffering, and harm to their mental and physical well-being. *See e.g., Lopez v. Heckler,* 713 F.2d 1432, 1437 (9th Cir. 1983). In light of the significant threat to the health of Medi-Cal recipients, reducing payments to health-care service providers will likely cause, and given that nothing in this Court's order prevents respondent from imposing a rate reduction after she has appropriately considered and applied the relevant factors, the Court finds that the balance of hardships tips in favor of granting the preliminary injunction.

## E. PUBLIC INTEREST

"The district court's public interest analysis should be whether there exists some critical public interest that would be injured by the grant of preliminary relief." *Hybritech,* 849 F.2d at 1458. Clearly, there is a public interest in ensuring that the State has enough money to meet its financial obligations in the face of competing demands. However, there is also a public interest in ensuring access to health care. In light of all the circumstances, including the fact that the State may decide to implement a rate change upon making a properly reasoned and supported analysis, the Court finds that the public interest does not weigh against the issuance of a preliminary injunction.

## IV. CONCLUSION

For the foregoing reasons, the Court GRANTS plaintiffs' motion for preliminary injunction. The Court hereby orders respondent Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191(b)(3), as modified by AB 1183 beginning on March 1, 2009, by refraining from reducing by five percent payments to pharmacies for prescription drugs (including prescription drugs and traditional over-the-counter drugs provided by prescription) provided under the Medi-Cal fee-for-service program.[8]

Dated: February 27, 2009

/s/ Christina A. Snyder
CHRISTINA A. SNYDER
UNITED STATES
DISTRICT JUDGE

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[8] Plaintiff's motion appears to seek an injunction as to the five percent rate reduction for all pharmacy products, not just drugs. However, plaintiffs' arguments regarding irreparable harm focus on brand and generic drugs dispensed by pharmacies; plaintiffs have not shown irreparable harm as to the effect of the five percent rate reduction on other pharmacy products. Therefore, the Court limits the scope of the injunction to drug products dispensed by pharmacies.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

**CIVIL MINUTES –GENERAL**

Case No. CV 09-382 CAS (MANx) Date April 3, 2009

Title Managed Pharmacy Care et al v. David Maxwell-Jolly

Present: The Honorable CHRISTINA A. SNYDER

| Catherine Jeang | Not Present | N/A |
|---|---|---|
| Deputy Clerk | Court Reporter/ Recorder | Tape No. |

| Attorneys Present for Plaintiffs: | Attorneys Present for Defendants: |
|---|---|
| Not Present | Not Present |

Proceedings: **(In Chambers:) Defendant's Motion to Alter or Amend, and Clarify the Court's February 27, 2009** (filed 3/13/2009)

The Court finds this motion appropriate for decision without oral argument. Fed. R. Civ. P. 78; Local Rule 7-15. Accordingly, the hearing date of April 6, 2009, is hereby vacated, and the matter is hereby taken under submission.

## I. INTRODUCTION AND BACKGROUND

On September 16, 2008, the California Legislature passed Assembly Bill 1183 ("AB 1183"), which was subsequently signed by the Governor and filed

with the Secretary of State on September 30, 2008. AB 1183 amends Cal. Welf. & Inst. Code. § 14105.19 and mandates that, effective March 1, 2009, Medi-Cal reimbursement payments to some fee-for-service providers will be reduced by one percent or five percent, depending on provider type. Particularly relevant to the instant action, AB 1183 enacts a modified Cal. Welf. Inst. Code § 14105.191(b)(3) so as to require that Medi-Cal fee-for-service payments to pharmacies be reduced by 5 percent.

These reductions mandated in AB 1183 replace the ten percent rate reduction put into place by Assembly Bill X3 5 ("AB 5"), which is scheduled to terminate on February 28, 2009. *See* Cal. Welf. & Inst. Code § 14105.19(b)(1). AB 5 was passed by the California Legislature on February 16, 2008. On August 18, 2008, the ten percent rate reduction mandated by AB 5 was partially enjoined by this Court in a related action, *Independent Living Center of Southern California, Inc. v. Sandra Shewry*, CV-08-3315 CAS (MANx). In issuing the preliminary injunction, this Court found that petitioners had, *inter alia*, demonstrated a strong likelihood of success in showing that AB 5 was preempted by § 30(A) of the Medicaid Act (referred to herein as " § 30(A)"). The Court's August 18, 2008 order is currently being appealed to the Court of Appeals for the Ninth Circuit.[1]

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[1] The Court's August 18, 2008 order was issued on remand from the Ninth Circuit, after plaintiffs appealed this Court's

(Continued on following page)

On January 16, 2009, Managed Pharmacy Care, Independent Living Center of Southern California, Inc., Gerald Shapiro, Sharon Steen, and Tran Pharmacy, Inc. filed the instant action against David Maxwell-Jolly, Director of the Department of Health Care Services of the State of California. Plaintiffs' complaint challenged the five percent Medi-Cal reimbursement rate reduction to providers of pharmacy services under AB 1183. Plaintiffs sought an order directing defendant "to set aside his preempted policy to implement § 14105.19 Welf. & Inst. Code, of AB 1183, and the 5% Rate Reduction, and, to refrain from implementing the same; including but not limited to refraining from reducing payments by five percent or by any other deduction, to pharmacy providers in the Medi-Cal FFS program, for services furnished on and after March 1, 2009."[2] Compl. at 8; Mot. at 1.

On February 2, 2009, plaintiffs filed a motion for a preliminary injunction. On February 27, 2009, the Court granted plaintiffs' motion for preliminary

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original June 25, 2008 ruling on their preliminary injunction motion. The Court's June 25, 2008 order found that plaintiffs in *Independent Living* lacked any federal rights under § 30(A), and therefore had denied petitioners' motion for preliminary injunction. On appeal, the Ninth Circuit held that plaintiffs could bring suit under the Supremacy Clause to enjoin AB 5 as preempted under the Medicaid Act, and remanded to this Court. *See Independent Living Center of Southern California et. al. v. Sandra Shewry et al.*, 543 F.3d 1050 (9th Cir. 2008).

[1] On January 26, 2009, plaintiff Managed Pharmacy Care was voluntarily dismissed as a plaintiff in this action.

injunction and ordered the Department to refrain from reducing by five percent payments to pharmacies for prescription drugs provided under the Medi-Cal fee-for-service program.

On March 13, 2009, defendant filed the instant motion to alter or amend and clarify the Court's February 27, 2009 order granting plaintiff's motion for preliminary injunction. Plaintiffs filed an opposition on March 23, 2009. A reply was filed on March 30, 2009. After carefully considering the arguments set forth by the parties, the Court finds and concludes as follows.

## II. LEGAL STANDARD

Under Federal Rule of Civil Procedure 59(e), a "motion to alter or amend a judgment must be filed no later than 10 days after the entry of the judgment." There are four grounds upon which a Rule 59(e) motion may be granted:

> 1) the motion is necessary to correct manifest errors of law or fact upon which the judgment is based; 2) the moving party presents newly discovered or previously unavailable evidence; 3) the motion is necessary to prevent manifest injustice; or 4) there is an intervening change in controlling law.

*Turner v. Burlington Northern Santa Fe R.R.*, 338 F.3d 1058, 1063 (2003). However, a motion under Fed. R. Civ. P. 59(e) cannot be based on evidence and

arguments that could have reasonably been presented earlier in the litigation. *Carroll v. Nakatani*, 342 F.3d 935, 945 (9th Cir. 2003); Judge William W. Schwarzer, et al., *California Practice Guide: Federal Civil Procedure Before Trial* § 12:159.2 (The Rutter Group 2007).

## III. DISCUSSION

Defendant argues that "the Court committed manifest error of law or fact in the Order granting Plaintiff's request for preliminary injunction by: (1) finding that the California Legislature had a duty to consider 'any of the relevant factors' prior to the implementation of AB 1183 . . . ; (2) finding that the legislature did not consider any of the said relevant factors . . . ; and (3) improperly analyzing the evidence regarding the aggregate amount of Medi-Cal reimbursement for all drugs, including multi-source drugs." Mot. at 2.

With regard to the Legislature's duty to consider the relevant factors, defendant argues that the Court was incorrect in its finding that the holding of *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997) (hereinafter, *Orthopaedic II/III*) required the Legislature to consider the relevant factors prior to reducing Medi-Cal reimbursement rates. Mot. at 2. Instead, plaintiff argues, "[i]f there is a legal obligation in § (a)(30) (A) to conduct a study, analysis, or give some sort of consideration of 'EEQ' in making rate changes, the federal Medicaid law is clear that

any such obligation would not be on a state's legislature, but rather on a state's single state agency." Mot. at 4. However, as the Court set forth in its preliminary injunction order, and in the Court's March 9, 2009 preliminary injunction orders in the related action CV 09-722-CAS *California Pharmacists Association, et al. v. David Maxwell Jolly*, the Court disagrees with defendant's reading of *Orthopaedic II/III*, and instead finds that *Orthopaedic II/III* indicates that the body responsible for rate setting (here, the Legislature) must consider the relevant factors prior to or contemporaneously with the adoption of the rates.[3] Therefore, the Court declines to alter or amend its holding regarding the Legislature's responsibility to consider the relevant factors.

With regard to the Court's finding that the Legislature failed to consider the relevant factors, defendant argues that the Court committed "manifest error of law or fact by accepting Plaintiffs' inaccurate argument" regarding the legislative history of AB 1183. Mot. at 6. Defendant requests that the Court take judicial notice of evidence not submitted with its opposition, but submitted with its oppositions in the related action CV 09-722-CAS *California Pharmacists Association, et al. v. David Maxwell Jolly*. This

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[3] The Court notes that the result of this case might have been different had the Legislature delegated the study of the relevant factors to the Department or another body, and subsequently considered the results of that study prior to approving the rate reduction.

evidence, defendant argues, demonstrates that the Legislature did, in fact, consider the relevant factors in passing AB 1183. Plaintiff responds that the evidence and documents submitted by defendant in his request for judicial notice were known and available to the plaintiff at the time of the hearing, and therefore they should not be considered herein. Opp'n at 5. Defendant responds that in fact, defendant's counsel called the Court's attention to similar evidence at the hearing when defendant argued that "AB 1183 just didn't come out of thin air. There were many meetings throughout the year . . . [t]here was a legislative budget committee that worked on it. There were meetings." Reply at 4, citing Reporter's Transcript 7:4-13.

The Court concludes that, regardless of the question of whether defendant properly submitted the evidence on which it now relies in its opposition to plaintiff's motion in this action, the Court fully considered this evidence when it was submitted with defendant's oppositions with regard to motions for preliminary injunction in the related action CV 09-722-CAS *California Pharmacists Association, et al. v. David Maxwell Jolly,* and determined that defendant's evidence did not demonstrate that the Legislature relied on responsible cost studies providing reliable data in setting the rates. Therefore, the Court determines that defendant has failed to demonstrate that the Court committed manifest error of law or fact in determining that the Legislature did not consider the relevant factors.

Finally, with regard to the Court's finding of irreparable harm, defendant argues that the Court erred in finding irreparable harm as to the rate reduction for multi-source drugs, given that the Department's evidence indicated that, after the implementation of the rate reduction, the aggregate Medi-Cal reimbursement for multi-source drugs would be 107 percent to 137 percent of costs. Mot. at 8. Defendant argues that "[i]f the Court concludes that anything less than 100 percent reimbursement of pharmacy costs causes irreparable harm as a result of potential equal access issues, the flip side of that conclusion is that anything above 100 percent reimbursement does not cause irreparable harm." Mot. at 8. Furthermore, defendant argues that the Court's order should be altered "to only enjoin a payment reduction that exceeds 3% on single source drugs," given that the defendants' evidence demonstrates that the reimbursement rate for single source drugs would be 98-99 percent of costs. Mot. at 9.

However, the Court finds that defendant has failed to demonstrate that the Court committed manifest error of fact in finding irreparable harm. The Court considered all of the evidence, including defendant's evidence regarding reimbursement for multi-source drugs, and determined that plaintiffs had demonstrated that the rate reductions would cause irreparable harm, particularly to certain independent pharmacies. As the Court stated in its order, for example, plaintiffs' submitted declarations "show that independent pharmacy providers, who

constitute approximately thirty-three percent of the licensed community pharmacies in California, will be hard-hit by the five percent rate reduction, and may discontinue, or at least severely reduce, services to Medi-Cal beneficiaries." Defendant's showing that the reimbursement rate for multi-source drugs would be over 100 percent of costs on *average* under AB 1183 does not negate plaintiff's showing that some independent pharmacies who may have higher than average costs may be forced to reduce services or to close as a result of the rate reductions. As a result, some Medi-Cal beneficiaries may be irreparably harmed due to lost access to needed services.

## IV. CONCLUSION

For the foregoing reasons, the Court DENIES defendant's motion to alter, amend or clarify the Court's February 27, 2009 order.

IT IS SO ORDERED.

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

| | |
|---|---|
| MIKESHA MARTINEZ, et al., Plaintiffs, v. ARNOLD SCHWARZENEGGER, et al., Defendants. / | No. C 09-02306 CW ORDER GRANTING PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION (Filed Jun. 26, 2009) |

This case is about the implementation of cuts to the wages paid to In-Home Support Services (IHSS) providers, who provide in-home assistance to low-income elderly and disabled individuals through California's Medi-Cal program. The cuts are scheduled to go into effect July 1, 2009. Plaintiffs are a proposed class of individuals who currently receive assistance through IHSS and the unions who represent IHSS providers. In this motion, Plaintiffs seek to enjoin the implementation of the law that will result in cuts to IHSS providers' wages. Defendants Governor Arnold Schwarzenegger, Director of the California Department of Social Services John A. Wagner, Director of the California Department of Health Care Services David Maxwell-Jolly, Fresno County and Fresno County In-Home Supportive Services Public Authority oppose the motion.[1] The matter was heard

[1] Defendant State Controller takes no position in this matter.

on June 25, 2009. Having considered all of the parties' papers and oral argument on the motion, the Court concludes that Plaintiffs have established a strong likelihood of success on their claim that the State Defendants have violated the procedural requirements of the Medicaid Act. The Court also concludes that Plaintiffs will suffer an irreparable injury if the IHSS cuts are implemented and, furthermore, the cuts are reasonably likely to cost the State more money in the long run as individuals currently receiving in-home health services are required to turn to institutionalized care due to the difficulty of finding IHHS providers willing to work for the reduced wages. Accordingly, the Court grants the preliminary injunction.

## BACKGROUND[1]

In 1973, California established the IHSS program to provide assistance with the tasks of daily living to low-income elderly and disabled persons "who cannot safely remain in their homes or abodes of their own choosing unless these services are provided." Cal. Welf. & Inst. Code § 12300(a). IHSS

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[1] The Court takes judicial notice of Plaintiffs' exhibits A through X to their request and the State Defendants' exhibits A and B to their request. These documents consist of legislative history and publications by federal, state, local officials and agencies which contain facts that are not subject to reasonable dispute in that they are capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned.

providers give services such as assistance with bathing, dressing, cooking, feeding, bowel and bladder care, self-administration of medication and cleaning. *Id.* § 12300(b), (c). Over 360,000 IHSS providers serve over 440,000 individuals in California. Over sixty-two percent of IHSS recipients are served by a relative.

IHSS is administered by the State's counties. Fifty-six of California's fifty-eight counties have established either a public authority (PA) or a non-profit consortium (NPC) to provide the delivery of IHSS services. Each of these fifty-six counties has created and maintains a registry from which service providers can be drawn. As of June 30, 2007, there were over 14,500 persons in county registries.[3] These PAs and NPCs are considered employers of IHSS providers for some purposes, including collective bargaining agreements pertaining to providers' wages and benefits; however, individual consumers hire, fire and supervise their own IHSS providers. *Id.* § 12301.6(c)(1).

Each county establishes the providers' wages and benefits. Thus, the rates paid to IHSS providers vary by county. Because most IHSS consumers participate in California's Medicaid program, the federal government pays for about fifty percent of the IHSS program's costs. *See* 42 U.S.C. § 1396d(b). The State pays sixty-five percent and the county pays thirty-five

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[3] The parties did not provide a more recent estimate for the number of IHSS providers in county registries.

percent of the remaining half of the program's costs. Cal. Welf. & Inst. Code § 12306. The State's contribution, however, is subject to a statutory cap. Currently, the maximum State contribution is sixty-five percent of the non-federal share of a wage and benefit package of $12.10 per hour. *Id.* at 12306.1(c)-(d).

Wages and benefits are determined through the collective bargaining process at the county level. Once these wages and benefits are decided, they must be submitted to the California Department of Health Care Services to ensure that they comply with all applicable state and federal laws. *Id.* § 12306.1(a)-(b).

In response to California's unprecedented budget crisis, on February 20, 2009, the Governor signed into law California Welfare and Institutions Code § 12306.1(d)(6). If that law goes into effect on July 1, 2009, the State's maximum contribution in wages and benefits will be reduced from sixty-five percent of the nonfederal share of an hourly rate of $12.10 to sixty-five percent of the non-federal share of an hourly rate of $10.10. This rate represents $9.50 for wages and $0.60 for benefits. Counties do not have to reduce wages and benefits and are permitted to make up the difference between the State's current contribution and any reduction that may result from the State's new maximum contribution.

Only counties that currently pay IHSS providers more than $10.10 per hour in wages and benefits will see a reduction in the State's contribution to IHSS costs. Currently, thirty-four of the fifty-six PAs and

NPCs pay IHSS providers $10.10 per hour or less in wages and benefits. Thus, there will be no reduction in the State's contribution to IHSS costs in a majority of the counties, including Los Angeles, where forty-two percent of all IHSS services are provided. Of the twenty-two counties that currently pay wages and benefits of more than $10.10 per hour to IHSS providers, twelve have notified the State of their intent to reduce IHSS wages in proportion to the anticipated reduction in the State's contribution. Of those twelve counties, Fresno is the only one named as a Defendant. The remaining ten counties have existing labor contracts that will not expire until fall, 2009, and the State does not know what each county will do once those contracts expire.

Fresno is the only county Plaintiffs have sued in this case. On September 26, 2006, the Fresno County Board of Supervisors approved a Memorandum of Understanding (MOU) between the Fresno IHSS Public Authority and the Service Employees International Union, California State Council (SEIU).

The MOU identifies specific contingencies which would permit the County to reduce wages and benefits from their current levels:

> If at any time, federal or state IHSS funding, including monies received through the Realignment Act, are reduced and/or suspended, the Public Authority's participation in pay and wages and/or benefits shall be reduced in direct proportion. The PA shall

> notify the Union of the extent and implementation date of the reduction.
>
> With respect to state realignment and reimbursements, fluctuations in arrears payments within the normal course of the realignment system/process, as of the date of signing the MOU, are not intended to trigger this section.
>
> Fluctuation in total provider service hours do not reduce or increase the per hour wage/benefit rate.

If the union disagrees with a wage or benefit reduction or with the amount of the reduction, the MOU provides that "the parties agree to submit the issue to a neutral third party fact finder for determination of the necessity for and the amount of the reduction." After the bill enacting § 12306.1(d)(6) was signed into law, the Fresno County Board of Supervisors invoked the contingencies article of the MOU to notify the union that it would be reducing the wage and benefits paid to IHSS providers from the current combined hourly rate of $11.10 to a combined hourly rate of $10.10, effective July 1, 2009. If the County continued to pay IHSS providers wages and benefits of $11.10 per hour after the State's maximum contribution is reduced to sixty-five percent of the non-federal portion of a payment of $10.10 per hour, it would incur an additional $6 million in costs annually. The County claims to be in dire financial straits already, with a proposed 2009-2010 budget that anticipates a reduction of $41.44 million in

revenues. The County notes that, as of June 10, 1009 [sic], there are 450 pre-qualified IHSS providers on the county provider registry actively seeking work as an IHSS provider.

In their complaint, Plaintiffs allege that the wage reduction provided in § 12306.1(d)(6) will have a substantial financial impact on tens of thousands of IHSS providers throughout the state. Plaintiffs' expert, Economics Professor Candace Howes, estimates that approximately 4,000 providers will leave IHSS employment because of the rate reduction and that 2,700 IHSS consumers will be unable to find replacements. Howes estimates that over one-fifth of these consumers will try to remain at home without assistance from an IHSS provider, which could be dangerous for the consumer. Roughly half of those unable to find replacement (approximately 1,400) may have to enter skilled-nursing-facilities or other residential institutions.[4] At the hearing on the

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[4] Each side has challenged the admissibility of the evidence submitted by the other side. However, on a motion for a preliminary injunction, the Court may consider inadmissible evidence, giving such evidence appropriate weight depending on the competence, personal knowledge, and credibility of the declarants. 11A Charles A. Wright, Arthur K. Miller & Mary K. Kane, *Federal Practice and Procedure* § 2949 at 216-217 (2d ed.1995); *see also Flynt Distrib. Co. v. Harvey*, 734 F.2d 1389, 1394 (9th Cir. 1984) ("The urgency of obtaining a preliminary injunction necessitates a prompt determination and makes it difficult to obtain affidavits from persons who would be competent to testify at trial. The trial court may give even inadmissible evidence some weight, when to do so serves the

(Continued on following page)

present motion, defense counsel acknowledged that it costs the State more money to pay for individuals in residential institutions than to pay for home health care services.

## LEGAL STANDARD

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Res. Def. Council, Inc.*, ___ U.S. ___, 129 S. Ct. 365, 374 (2008). "[T]he required showing of harm varies inversely with the required showing of meritoriousness." *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1047, 1049 (9th Cir. 2008) (quoting *Rodeo Collection, Ltd. v. W. Seventh*, 812 F.2d 1215, 1217 (9th Cir. 1987)). "When the balance of harm 'tips decidedly toward the plaintiff,' injunctive relief may be granted if the plaintiff raises questions 'serious enough to require litigation.'" *Id.* (quoting *Benda v. Grand Lodge of the Int'l Ass'n of Machinists & Aerospace Workers*, 584 F.2d 308, 315 (9th Cir. 1978)).

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purpose of preventing irreparable harm.") Therefore, the Court will exercise its discretion to consider the proffered evidence as appropriate.

## DISCUSSION

### I. Likelihood of Success on the Merits

To receive federal financial participation in payment for services that states provide to low income persons who are aged, blind, disabled or members of families with dependent children, states must agree to comply with applicable federal Medicaid law. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1493 (9th Cir. 1997). The Medicaid Act requires a participating state to develop a state plan which describes the policy and methods to be used to set payment rates for each type of service included in the program. 42 C.F.R. § 447.201(b). A provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A) (hereinafter Section 30(A)), requires, in relevant part, that a state's Medicaid plan:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Defendants urge that Section 30(A) does not compel the state to conduct any studies or analyses regarding the impact of a rate cut. Defendants rely largely on *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005),

which they contend limited the holding in *Orthopaedic Hospital* to its facts.

In *Orthopaedic Hospital,* hospital providers sued the California Department of Health Services, claiming that the Director violated Section 30(A) by reducing reimbursement rates without considering the effect of hospital costs on efficiency, economy and quality of care. The Ninth Circuit held that Section 30(A) "provides that payments for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Orthopaedic Hosp.,* 103 F.3d at 1496 (emphasis in original). The Ninth Circuit concluded that, under Section 30(A),

> the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

*Id.* The court also concluded, "It is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons." *Id.* at 1499 n.3.

Subsequently, in *Sanchez v. Johnson,* 416 F.3d 1051, 1060 (9th Cir. 2005), the Ninth Circuit held

that Section 30(A) does not confer individual rights that are enforceable under 42 U.S.C. § 1983.[4] *Sanchez* left undisturbed the rule announced in *Orthopaedic Hospital* that Section 30(A) "requires the state to consider efficiency, economy, quality of care, and access before setting Medi-Cal reimbursement rates." *California Pharmacists Assoc. v. Maxwell-Jolly*, 563 F.3d 847, 850 (9th Cir. 2009) (citing *Orthopaedic Hosp.*, 103 F.3d at 1496).

Here, the State Defendants concede that the California legislature did not consider the Section 30(A) factors when it adopted California Welfare and Institutions Code § 12301(d)(6). The bill implementing § 12301(d)(6) states only that the new law "addresses the fiscal emergency declared by the Governor by proclamation on December 19, 2008." No analysis in the legislative history mentions the impact of the provision on access to care or the quality of care.

Defendants argue that they need not consider the Section 30(A) factors because the wages and benefits paid to IHSS providers are set by the counties' PA or NPC, often after collective bargaining. Defendants assert that the State has no influence in determining what the wages will be in each county. However

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[4] However, in *Independent Living Center of Southern California, Inc. v. Shewry*, 543 F.3d 1050, 1058 (9th Cir. 2008), the Ninth Circuit held that a plaintiff may sue for injunctive relief directly under the Supremacy Clause. Here, Plaintiffs sue under that clause.

§ 12306.1(d)(6) has a direct influence on the wages for each county because it reduces the maximum payment towards wages and benefits that the State will contribute. Through § 12306.1(d)(6), the State directly informed all counties that it would no longer be able to contribute more than sixty-five percent of the non-federal portion of $10.10 per hour in wages and benefits. Further, a county's role in determining IHHS wages and benefits does not preclude the State from analyzing the impact of Section 12306.1(d)(6) on the Section 30(A) factors prior to enactment. Accordingly, the Court concludes that Plaintiffs have made a strong showing of likelihood of success on the merits that Defendants violated the procedural requirements of Section 30(A).

Because the Court concludes that a preliminary injunction is warranted based on Plaintiffs' likelihood of success on their procedural claim, the Court need not determine the likelihood of Plaintiffs' success on their claim that Defendants violated the substantive requirements of Section 30(A) or their claim that Defendants violated the Americans with Disabilities Act.

## II. Irreparable Harm, Balance of Hardships and the Public Interest

IHSS consumers will suffer immediate and irreparable harm unless the Court issues a preliminary injunction. The wage reductions will cause many IHSS providers to leave employment, which in turn

will leave consumers without IHSS assistance. The consumers' quality of life and health-care will be greatly diminished, which will likely cause great harm to disabled individuals. For instance, the declarations submitted by Plaintiffs describe harms ranging from going hungry and dehydration, to falls and burns, to an inability ever to leave the home. Institutionalizing individuals that can comfortably survive in their home with the help of IHSS providers will "cause Plaintiffs to suffer injury to their mental and physical health, including a shortened life, and even death for some Plaintiffs." *Crabtree v. Goetz*, 2008 WL 5330506, at *30 (M.D. Tenn.).

IHSS providers will also suffer immediate and irreparable harm. Although financial injury is generally not adequate to establish irreparable harm, *L.A. Mem'l Coliseum Comm'n v. Nat'l Football League*, 643 F.2d 1197, 1202 (9th Cir. 1980), financial harm to the IHSS providers is irreparable because retrospective monetary damages are unavailable due to the State Defendants' Eleventh Amendment immunity. *California Pharmacists*, 563 F.3d at 851-52 ("[B]ecause the Hospital Plaintiffs and their members will be unable to recover damages against the Department even if they are successful on the merits of their case, they will suffer irreparable harm if the requested injunction is not granted.")

The balance of hardships and the public interest also weigh in Plaintiffs' favor. If the preliminary injunction does not issue, the State Defendants' sole injury will be the financial costs associated with

continuing to participate under the current IHSS provider wages. The Court notes that there is persuasive evidence that the wage cuts will actually cost the State tens of millions of additional dollars because in-home care is considerably less expensive than institutionalized care and IHHS providers reduce the need for expensive emergency room visits. Accordingly, the financial loss the State will suffer if Section 12306.1(d)(6) is not implemented does not outweigh the hardship Plaintiffs would suffer absent an injunction. Lastly, the public interest weighs heavily in favor of granting relief. "It would be tragic, not only from the standpoint of the individuals involved but also from the standpoint of society, were poor, elderly, disabled people to be wrongfully deprived of essential benefits for any period of time." *Lopez v. Heckler,* 713 F.2d 1432, 1437 (9th Cir. 1983).

## CONCLUSION

For the foregoing reasons, the Court grants Plaintiffs' motion for a preliminary injunction. As set forth in the separately filed preliminary injunction, Defendants are enjoined and restrained from implementing California Welfare and Institutions Code § 12306.1(d)(6) without first conducting the analysis required by Section 30(A), as described in *Orthopaedic Hospital.*

IT IS SO ORDERED.

Dated: 6/26/09 /s/ Claudia Wilken
CLAUDIA WILKEN
United States District Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN
DISTRICT OF CALIFORNIA

MIKESHA MARTINEZ, et al.,

Plaintiffs,

v.

ARNOLD
SCHWARZENEGGER, et al.,

Defendants. /

No. C 09-02306 CW

PRELIMINARY
INJUNCTION

IT IS HEREBY ORDERED that Defendants ARNOLD SCHWARZENEGGER, Governor of the State of California; JOHN A. WAGNER, Director of the California Department of Social Services; DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services; JOHN CHIANG, California State Controller; and their officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them, are HEREBY ENJOINED AND RESTRAINED from implementing California Welfare and Institutions Code § 12306.1(d)(6) without first conducting the analysis required by 42 U.S.C. § 1396a(a)(30)(A), as described in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1941, 1493 [sic] (9th Cir. 1997).

A reasoned written order will follow.

IT IS SO ORDERED.

Dated: 6/26/2009 /s/ Claudia Wilken
CLAUDIA WILKEN
United States District Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN
DISTRICT OF CALIFORNIA

MIKESHA MARTINEZ, et al.,

Plaintiffs,

v.

ARNOLD
SCHWARZENEGGER, et al.,

Defendants. /

No. C 09-02306 CW

AMENDED
PRELIMINARY
INJUNCTION

IT IS HEREBY ORDERED that Defendants ARNOLD SCHWARZENEGGER, Governor of the State of California; JOHN A. WAGNER, Director of the California Department of Social Services; DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services; JOHN CHIANG, California State Controller; and their officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them, are HEREBY ENJOINED AND RESTRAINED from implementing California Welfare and Institutions Code § 12306.1(d)(6) without first conducting the analysis required by 42 U.S.C. § 1396a(a)(30)(A), as described in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1941, 1493 [sic] (9th Cir. 1997). IT IS FURTHER ORDERED that State Defendants shall, by the close of business on July 14, 2009, rescind the State's approval of all county rate reduction requests which were submitted after February 20, 2009, to be effective July 1, 2009,

and reinstate the State's approval of the pre-July 1 rates. The State shall notify each affected county of these action [sic], using a method designed to ensure that the notification is received on July 14. At the same time, the State will notify these counties that it will pay sixty-five percent of the non-federal share of the pre-July 1, 2009 rate up to $12.10 for hours worked on July 1 and thereafter, until such time as the Court's preliminary injunction is rescinded. The State shall include a copy of the Court's amended injunction in its communication to the counties. The State may notify the counties that they may submit new Rate Change Requests if they wish to pursue a rate change for reasons other than the passage of § 12306.1(d)(6).

IT IS SO ORDERED.

Dated: 07/13/09 /s/ Claudia Wilken
CLAUDIA WILKEN
United States District Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

MIKESHA MARTINEZ, et al.,

Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants. /

No. C 09-02306 CW

ORDER FURTHER CLARIFYING INJUNCTION

(Filed Jul. 24, 2009)

On June 26, 2009, the Court enjoined and restrained Defendants from implementing California Welfare and Institutions Code § 12306.1(d)(6) without first conducting the analysis required by 42 U.S.C. § 1396a(a)(30)(A), as described in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1941, 1943 (9th Cir. 1997). In response to Plaintiffs' motion for civil contempt sanctions, or in the alternative, for a more specific injunction, the Court issued an order clarifying the injunction. The Court ordered that "State Defendants shall, by the close of business on July 14, 2009, rescind the State's approval of all county rate reduction requests which were submitted after February 20, 2009, to be effective July 1, 2009, and reinstate the State's approval of the pre-July 1 rates." Amd. Prelim. Inj. at 1. The Court also stated, "The State may notify the counties that may submit new Rate Change Requests if they wish to pursue a rate change for reasons other than the passage of § 12306.1(d)(6)."

Order Clarifying Inj. at 6. With respect to Fresno County, the Court noted,

> It is not clear from the papers submitted by the parties whether Fresno County submitted one Rate Change Request with a second reason for the request other than the passage of § 12306.1(d)(6) or if it submitted two requests. If it submitted only one request, it must submit a separate request based on a reason other than § 12306.1(d)(6) if it wishes to pursue a rate reduction.

*Id.* at 6 n.4.

Although the order clarifying the injunction specifically instructed State Defendants to "rescind the State's approval of *all* county rate reduction requests which were submitted after February 20, 2009," (emphasis added) California Department of Social Services (CDSS) official Eileen Carroll instead contacted several counties to see if they wanted to revert to the pre-July 1, 2009 wage. Officials of Fresno County and Santa Barbara County indicated that they did not want return to the pre-July 1 wage because they claim a separate and independent reason for their rate reduction. Fresno County officials assert that it had filed a separate Rate Change Request on June 24, giving a separate and independent ground for its rate reduction; and Santa Barbara County officials subsequently submitted a

similar Rate Change Request on July 21.[1] The State did not rescind its approval of Fresno County's and Santa Barbara County's rate reduction request.

Carroll also told at least one In-Home Support Services (IHSS) Public Authority that if State Defendants prevailed in the instant lawsuit and § 12301.6(d)(d) is eventually implemented, counties would be reasonsible for the state contribution above $9.50 retroactive to July 1, 2009. Arkush Supp. Decl. ¶ 2. The Court has made no such ruling.

On July 14, 2009, State Defendants issued a notice to all counties informing them that the State would not begin paying the pre-July 1 rates until July 23. State Defendants claim that the Department of Social Services could not change the levels of wages and benefits to be paid to IHSS providers in its Case Management, Information and Payrolling System (CMIPS) until July 23. By that date, the CMIPS system would be reprogrammed. Even after July 23, State Defendants will not pay the pre-July 1 levels of wages and benefits retroactively to July 1 until the counties submit a supplemental pay warrant. State Defendants claim, "Under DSS regulations counties

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[1] The parties acknowledge that Contra Costa County has indicated that, instead of reverting to the pre-July 1 wage rate, it intends to implement its more recent rate request, which seeks to implement wages above the pre-July 1 level. Plaintiffs do not oppose this decision.

are required to process all supplemental payments."[2] Letter from State Defendants to Judge Wilken Re Complying with Amended Preliminary Injunction. In order to submit a supplemental pay warrant, according to State Defendants, counties must "complete a 'spec transaction'" that will take [sic] "take 20-25 minutes per case."[3] All-County Welfare Director's Letter at 3.

Plaintiffs have now filed another motion for civil contempt sanctions and for a further, more specific preliminary injunction. Defendants oppose the motion. Having considered the papers filed by the parties, the Court further clarifies its injunction and takes Plaintiffs' motion for contempt sanctions under submission.

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[1] Although State Defendants do not cite any particular regulations for this requirement, it appears that they are referring to Social Services Standard 30-769.252, which provides, "The county shall initiate emergency/supplemental checks" in certain situations, including "[p]ayments for other unusual situations not provided for by the regular payrolling process." Nothing in this standard prohibits the State from initiating a supplemental payment on its own.

[2] According to the State, each county must manually calculate the difference between the reduced wage and the reinstated wage, multiply that figure by the number of hours worked at the reduced wage, and enter that amount into the CMIPS. Plaintiffs estimate that this process would take a small county such as San Benito, which only has 420 IHSS consumers, up to ten working days to complete.

## DISCUSSION

Under the plain terms of the Court's amended preliminary injunction, State Defendants were ordered to, "by close of business on July 14, 2009, rescind the State's approval of all county rate reduction requests which were submitted after February 20, 2009, to be effective July 1, 2009, and reinstate the State's approval of the pre-July 1, rates." Amd. Prelim. Inj. at 2. The Court was specific in its order because, up until that point, State Defendants' manner of compliance with the original preliminary injunction did not carry out the intent of the order. Thus, when State Defendants refused to rescind their approval of Santa Barbara's rate reduction request submitted during the specified time period, they were in violation of the Court's amended injunction.

The facts related to Fresno County's Rate Change Request are more complicated. On April 30, 2009, Fresno County had submitted a Rate Change Request packet to the CDSS. Included in the packet was form SOC 449, entitled "In-Home Supportive Services Program Public Authority/Non-Profit Consortium Rate." Also in the packet, Fresno County included the April 28, 2009 Board of Supervisors' Agenda Item, in which the Board stated, "Based on the state maximum participation decrease in wages and benefits and the contingency language in the Memorandum of Understanding, the rate packet will insure that the provider wage decrease from $10.25 to $9.50 and benefit decrease from $.85 to $.60 per hour becomes effective July 1, 2009." The Memorandum of Understanding

provides specific contingencies which would permit Fresno to pay lower wages and benefits to IHSS providers.

On June 16, 2009, the Board had approved an agenda item for a $1.00 decrease in wages and benefits based on a purported budget realignment shortfall. The agenda item stated that there would be "no increase in net County cost associated with this action as the recommendation mirrors the recommendation adopted by the Governing Board on April 28, 2009." Leyton Second Supp. Decl., Ex. C (June 16 Agenda Item at 1). The agenda item further stated,

> The $1.00 recommended reduction before you today is specific to the Realignment deficit, and it is recommended that the reduction be divided between wages ($0.75) and benefits ($0.25) to be consistent with the State law change and the Public Authority Rate packet approved by the Governing Board on April 28, 2009. The approval of the recommended action would add a secondary reason to the rate packet submitted to the State, but is not an additional wage/benefits reduction.

*Id.* at 2.

On June 24, 2009, Fresno County submitted a letter to CDSS stating,

> Enclosed is the approved Board agenda item supporting the Fresno County submission of State Form SOC 449 sent to you on April 30, 2009. Please note that there are no changes that will be made to the submitted SOC 449

> form. Independent of the State law changes, on June 16, 2009, the Fresno County Board of Supervisors, sitting as the In-Home Supportive Services Public Authority Governing Board (Governing Board), voted to decrease wages and benefits due to loss of realignment funding.

Form SOC 449 is a budget narrative and does not include any information regarding the reasons for seeking approval of a rate change. Thus, a second reason for reducing wages did not affect the budget narrative provided in SOC 449.

As noted above, the Court ordered State Defendants to notify counties that they may submit new Rate Change Requests if they wished to pursue a rate change for reasons other than the passage of § 12306.1(d)(6). The Court noted that if Fresno County had submitted only a single previous Rate Change Request, with a second reason for the request other than the passage of § 12306.1(d)(6), and it wished to pursue a rate reduction, it would have to submit a separate request based on a reason other than § 12306.1(d)(6). The Court concludes that the June 24, 2009 letter merely expresses a second reason for its initial rate change request submitted on April 30, 2009. The letter does not constitute a second rate change request.

Moreover, at the time the Fresno County Board of Supervisors voted to submit the realignment shortfall as a separate reason for the April 30, 2009 Rate Change Request, § 12306.1(d)(6) was good law

and scheduled to go into effect on July 1, 2009. Thus, Fresno County either had to reduce its rate or make up the shortfall that the cut in the State's contribution would have created. Many presentations were made to the Board about the fiscal impact of the proposed rate cut, and these presentations presumed that § 12306.1(d)(6) would be implemented on July 1, 2009. The possibility that § 12306.1(d)(6) could be enjoined was not discussed at the Board meeting. Therefore, unless Fresno County submits a new Rate Change Request solely based on a reason other than the passage of § 12306.1(d)(6), it will not be clear whether the Fresno County Board of Supervisors would vote to seek a rate reduction knowing that § 12306.1(d)(6) has been preliminary enjoined.

Thus, to comply with the plain language of the Court's order clarifying the injunction, the State must rescind its prior approval of Santa Barbara and Fresno County's Rate Change Requests. To avoid misunderstandings, these rescissions must be in writing and be sent by overnight delivery within one business day from the date of this order. At the same time, a copy must be submitted to Plaintiffs' counsel and to the Court, along with a declaration under penalty of perjury verifying that it was sent. Before the State may approve a rate reduction for Santa Barbara or Fresno County, it must receive from the County a new and separate written request conforming to all the requirements of law and regulation, based on a reason other than § 12306.1(d)(6). A copy of this request shall be sent to the Court and to Plaintiffs'

counsel. The State may then approve the request in writing, if it accords with law and regulation.

The State must correct the underpayments made to providers for the July 1-15 pay period. The State has cited no regulation preventing it from preparing supplemental pay warrants. Counties should not be burdened with correcting the mistakes caused by State Defendants' violation of the federal Medicaid statute and failure to implement timely the Court's orders.

Therefore, State Defendants must pay IHSS providers, in all counties where the State has rescinded its approval of Rate Change Requests that proposed rate decreases to take effect July 1, 2009, at the correct, pre-July 1 rates in their regular paychecks for the pay period ending July 31, 2009. State Defendants must also pay all IHSS providers the correct amount owed for the pay period ending July 15, 2009 in a check or checks that issue no later than ten days after the provider submits his or her timesheet for that pay period, or seven business days from the date of this order, whichever is later. State Defendants shall file a declaration eight business days from the date of this order, verifying that they have done so or showing cause why they have not. In any county in which the State has approved an increase from the pre-July 1 rate, State Defendants shall pay such increased rate.

Plaintiffs' motion for civil contempt sanctions and attorneys' fees is taken under submission.

IT IS SO ORDERED.

Dated: 07/24/09 /s/ Claudia Wilken
CLAUDIA WILKEN
United States District Judge

## Assembly Bill No. 5

## CHAPTER 3

An act to amend Section 95004 of the Government Code, and to amend Sections 4640.6, 4643, 4648.4, 4681.3, 4681.5, 4691.6, 4781.6, and 4783 of, and to add Sections 4681.6, 4689.8, 4691.9, 14041.1, 14105.19, and 14166.245 to, the Welfare and Institutions Code, relating to health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor February 16, 2008.
Filed with Secretary of State February 16, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 5, Committee on Budget. Public health programs.

* * *

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital reimbursement methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. This demonstration project provides for funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including designated public hospitals, nondesignated public hospitals, and private hospitals, as defined in accordance with certain provisions relating to disproportionate share hospitals.

This bill would reduce by 10% payments for inpatient hospital services to acute care hospitals not under selective contracts with the department that are provided on and after July 1, 2008.

The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session for that purpose. The Governor issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on January 10, 2008.

This bill would state that it addresses the fiscal emergency declared by the Governor by proclamation issued on January 10, 2008, pursuant to the California Constitution.

This bill would declare that it is to take effect immediately as an urgency statute.

*The people of the State of California do enact as follows:*

* * *

SEC. 14. Section 14105.19 is added to the Welfare and Institutions Code, to read:

14105.19. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments as specified in this section.

(b)(1) Except as provided in subdivision (c), payments shall be reduced by 10 percent for Medi-Cal

fee-for-service benefits for dates of service on and after July 1, 2008.

(2) Except as provided in subdivision (c), payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after July 1, 2008.

(3) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reduction specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008.

(c) The services listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services, except for payments to hospitals not under contract with the State Department of Health Care Services, as provided in Section 14166.245.

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver under subdivision (a) of Section 1315 of Title 42 of the United States Code.

(3) Rural health clinic services.

(4) All of the following facilities:

(A) A skilled nursing facility pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, except a skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(B) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(C) A subacute care unit, as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(6) Hospice.

(7) Contract services as designated by the director pursuant to subdivision (e).

(8) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer

pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(9) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(10) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center.

(11) Breast and cervical cancer treatment provided pursuant to Section 14007.71.

(12) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(d) Subject to the exception for services listed in subdivision (c), the payment reductions required by subdivision (b) shall apply to the services rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of a provider bulletin,

or similar instruction, without taking regulatory action.

(f) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(g) The department shall promptly seek any necessary federal approvals for the implementation of this section.

SEC. 15. Section 14166.245 is added to the Welfare and Institutions Code, to read:

14166.245. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(c)(1) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Care Services, the reimbursement amount for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to 90 percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(d) Hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the 10 percent reduction required by this section.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement subdivision (b) by means of a provider bulletin, or other similar instruction, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

SEC. 16. This act addresses the fiscal emergency declared by the Governor by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 17. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make statutory changes needed to implement cost containment measures affecting health services, at the earliest possible time, it is necessary that this act take effect immediately.

## Assembly Bill No. 1183

## CHAPTER 758

An act to amend Sections 1266, 1279, 1324.21, 1324.23, 1324.28, 1324.29, 1324.30, 2805, 106925, 123853, 125191, 130501, 130506, and 130542 of, and to add Section 130542.1 to, the Health and Safety Code, to amend Sections 12693.43, 12693.63, and 12693.65 of, and to add Section 12693.271 to, the Insurance Code, and to amend Sections 4061, 4783, 4860, 5777, 14005.11, 14007.9, 14011.16, 14080, 14105.19, 14105.3, 14105.86, 14126.027, 14126.033, 14154, 14154.5, 14166.9, 14166.12, 14166.20, 14166.25, 14301.1, 14526.1, and 16809 of, to amend, repeal, and add Sections 14005.25 and 14166.245 of, to add Sections 4100.2, 4646.4, 7502.5, 14005.42, 14011.17, 14011.18, 14053.3, 14104.93, 14105.191, 14124.11, 14126.034, and 17605.051 to, and to add and repeal Article 2.93 (commencing with Section 14091.3), and Article 6.6 (commencing with Section 14199) of, Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to public health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 30, 2008. Filed with Secretary of State September 30, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1183, Committee on Budget. Health.

* * *

Existing law contains various provisions governing reimbursement rates, including rates for fee-for-service payments to Medi-Cal providers, and for providers of services received under various health programs, including the above-described programs, the Child Health and Disability Prevention Program, and specified family planning programs.

Existing law requires the Director of Health Care Services to reduce provider payments by 10% for both Medi-Cal fee-for-service benefits and services rendered by providers under these health programs for services rendered on or after July 1, 2008.

This bill would revise these provisions to require the 10% reduction of reimbursement rates to apply to services rendered on or after July 1, 2008, through and including dates of service on February 28, 2009. The bill would, for services rendered on a fee-for-services basis on or after March 1, 2009, require the director to reduce payments for certain benefits, including for services rendered by providers under the above-described health programs, by 1%, and to reduce payments to specified classes of providers and pharmacies by 5%, subject to certain exceptions. The bill would exempt small and rural hospitals, as defined, from the reduction, under specified circumstances.

The bill would specify that the reductions imposed pursuant to the bill would apply only to the General Fund share of the payment, and only to

payments for services from funds appropriated to the department.

To the extent federal financial participation is not available with respect to any of the payment reductions required pursuant to these provisions, the bill would authorize the director to not implement those payment reductions.

* * *

Existing law reduces by 10% payments for inpatient hospital services to acute care hospitals not under selective contracts with the department that are provided on and after July 1, 2008.

This bill, until January 1, 2013, would revise this provision by applying this reduction to all hospitals that receive Medi-Cal reimbursement from the department and that are not under selective contracts with the department. The bill, commencing October 1, 2008, and until January 1, 2013, would require the amounts paid for inpatient hospital services to be determined using a prescribed formula, subject to specified exceptions. If specified hospitals choose to enter into selective contracts with the department, the bill would require the California Medical Assistance Commission to negotiate reimbursement rates for those hospitals in accordance with specified criteria. The bill would require the department to report annually, from January 1, 2010, to January 1, 2012, inclusive, to the Legislature on

the implementation and impact made by the changes to these rate reduction provisions.

* * *

This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

*The people of the State of California do enact as follows:*

* * *

SEC. 44. Section 14105.19 of the Welfare and Institutions Code is amended to read:

14105.19. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments as specified in this section.

(b)(1) Except as provided in subdivision (c), payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after July 1, 2008, through and including dates of service on February 28, 2009.

(2) Except as provided in subdivision (c), payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after

July 1, 2008, through and including dates of service on February 28, 2009.

(3) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reduction specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008.

(4) Notwithstanding paragraphs (1) and (2), payment reductions set forth in this subdivision shall apply to small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, for dates of service on and after July 1, 2008, through and including October 31, 2008.

(c) The services listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services, except for payments to hospitals not under contract with the State Department of Health Care Services, as provided in Section 14166.245.

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver under subdivision (a) of Section 1315 of Title 42 of the United States Code.

(3) Rural health clinic services.

(4) All of the following facilities:

(A) A skilled nursing facility pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, except a skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(B) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(C) A subacute care unit, as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(6) Hospice.

(7) Contract services as designated by the director pursuant to subdivision (e).

(8) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(9) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(10) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center.

(11) Breast and cervical cancer treatment provided pursuant to Section 14007.71.

(12) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(d) Subject to the exception for services listed in subdivision (c), the payment reductions required by subdivision (b) shall apply to the services rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of a provider bulletin, or similar instruction, without taking regulatory action.

(f) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(g) The department shall promptly seek any necessary federal approvals for the implementation of this section.

SEC. 45. Section 14105.191 is added to the Welfare and Institutions Code, to read:

14105.191. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments, as specified in this section.

(b)(1) Except as otherwise provided in this section, payments shall be reduced by 1 percent for Medi-Cal fee-for-service benefits for dates of service on and after March 1, 2009.

(2) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, payments to the following classes of providers shall be reduced by 5 percent for Medi-Cal fee-for-service benefits:

(A) Intermediate care facilities, excluding those facilities identified in paragraph (5) of subdivision (d). For purposes of this section, "intermediate care facility" has the same meaning as defined in Section

51118 of Title 22 of the California Code of Regulations.

(B) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(C) Rural swing-bed facilities.

(D) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "subacute care unit" has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(E) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "pediatric subacute care unit" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(F) Adult day health care centers.

(3) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, Medi-Cal fee-for-service payments to pharmacies shall be reduced by 5 percent.

(4) Except as provided in subdivision (d), payments shall be reduced by 1 percent for non-Medi-Cal programs described in Article 6 (commencing with

Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after March 1, 2009.

(5) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008, or thereafter.

(c) Notwithstanding any other provision of this section, payments to hospitals that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to Section 14166.245 shall be governed by that section.

(d) To the extent applicable, the services, facilities, and payments listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver

pursuant to subsection (a) of Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Skilled nursing facilities licensed pursuant to subdivision (c) of Section 1250 of the Health and Safety Code other than those specified in paragraph (2) of subdivision (b).

(5) Intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(6) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(7) Hospice services.

(8) Contract services, as designated by the director pursuant to subdivision (f).

(9) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(10) Services pursuant to local assistance contracts and interagency agreements to the extent the

funding is not included in the funds appropriated to the department in the annual Budget Act.

(11) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into the Counties of Alameda, San Mateo, and Santa Clara pursuant to the Plan for the Closure of Agnews Developmental Center.

(12) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(13) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(14) Small and rural hospitals, as defined in Section 124840 of the Health and Safety Code.

(e) Subject to the exemptions listed in subdivision (d), the payment reductions required by paragraph (1) of subdivision (b) shall apply to the benefits rendered by any provider who may be authorized to bill for provision of the benefit, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2

of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking regulatory action.

(g) The reductions described in this section shall apply only to payments for benefits when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act, and shall not apply to payments for benefits paid with funds appropriated to other departments or agencies.

(h) The department shall promptly seek any necessary federal approvals for the implementation of this section. To the extent that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director may elect not to implement such reduction.

* * *

SEC. 57. Section 14166.245 of the Welfare and Institutions Code is amended to read:

14166.245. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b)(1) Notwithstanding any other provision of law, except as provided in Article 2.93 (commencing

with Section 14091.3), for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(2)(A) Beginning on October 1, 2008, amounts paid that are calculated pursuant to paragraph (1) shall not exceed the applicable regional average per diem contract rate for tertiary hospitals and for all other hospitals established as specified in subparagraph (C), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days for which the interim payment is being made.

(B) This paragraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on October 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds.

(C)(i) For purposes of this subdivision and subdivision (c), the average regional per diem contract rates shall be derived from unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in the California Medical Assistance Commission's Annual Report to the Legislature. For tertiary hospitals, and for all other hospitals, the regional average per diem contract rates shall be based on the geographic regions in the California Medical Assistance Commission's Annual Report to the Legislature. The applicable average regional per diem contract rates for tertiary hospitals and for all other hospitals shall be published by the department on or before October 1, 2008, and these rates shall be updated annually for each state fiscal year and shall become effective each July 1, thereafter. Supplemental payments shall not be included in this calculation.

(ii) For purposes of clause (i), both the federal and nonfederal share of the designated public hospital cost-based rates shall be included in the determination of the average contract rates by multiplying the hospital's interim rate, established pursuant to Section 14166.4 and that is in effect on June 1 of each year, by two.

(iii) For the purposes of this section, a tertiary hospital is a children's hospital specified in Section 10727, or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(D) For purposes of this section, the terms "open health facility planning area" and "closed health facility planning area" shall have the same meaning and be applied in the same manner as used by the California Medical Assistance Commission in the implementation of the hospital contracting program authorized in Article 2.6 (commencing with Section 14081).

(c)(1) Notwithstanding any other provision of law, for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services, pursuant to Article 2.6 (commencing with Section 14081), the reimbursement amount paid by the department for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to the lesser of the following:

(A) Ninety percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(B) Beginning for dates of service on and after October 1, 2008, the applicable average regional per diem contract rate established as specified in subparagraph (A) of paragraph (2) of subdivision (b), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year, or portion thereof. This subparagraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on July 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has more than three hospitals with licensed general acute care beds.

(d) Except as provided in Article 2.93 (commencing with Section 14091.3), hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and

Tuolumne General Hospital, shall be exempt from the limitations required by this section.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement and administer this section by means of provider bulletins, or other similar instructions, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g) Notwithstanding any other provision of this section, small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, shall be exempt from the payment reductions set forth in this section for dates of service on and after November 1, 2008.

(h) For hospitals that are subject to clauses (i) and (ii) of subparagraph (B) of paragraph (2) of subdivision (b) and that choose to contract pursuant to Article 2.6 (commencing with Section 14081), the California Medical Assistance Commission shall negotiate rates taking into account factors specified in Section 14083.

(i)(1) In January 2010 and in January 2011, the department and the California Medical Assistance Commission shall submit a written report to the policy and fiscal committees of the Legislature on the

implementation and impact of the changes made by this section, including, but not limited to, the impact of those changes on the number of hospitals that are contract and noncontract, patient access, and cost savings to the state.

(2) On or before January 1, 2012, the department, in consultation with the California Medical Assistance Commission, shall report on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing patient access, capacity and needs within the health facility planning area, reimbursement of hospital costs, changes in the number of open and closed health facility planning areas, the impact of this section on the extent of hospital contracting, and fiscal impact on the state.

(j) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

* * *

SEC. 76. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

**In order to make the necessary statutory changes to implement the Budget Act of 2008 at the earliest possible time, it is necessary that this act take effect immediately.**

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# Senate Bill No. 6

## CHAPTER 13

An act to amend Sections 4639.5, 4640.6, 11453, 12201, 12305.1, and 12306.1 of, and to add Sections 11450.02 and 12200.019 to, and to add and repeal Section 12200.018 of the Welfare and Institutions Code, relating to human services, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor February 20, 2009.
Filed with Secretary of State February 20, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

SB 6, Ducheny. Human services.

* * *

Existing law provides for the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization.

Existing law establishes the federal Medicaid program, which is administered by each state. California's version of this program is the Medi-Cal program, which is administered by the State Department of Health Services and under which qualified low-income persons receive health care benefits.

Existing law provides for the payment of a supplementary benefit under the IHSS program to any eligible aged, blind, or disabled person who is

receiving Medi-Cal personal care services and who would otherwise be deemed a categorically needy recipient under the IHSS program.

This bill would limit this supplementary payment to individuals who received Medi-Cal personal care services before July 1, 2009, who continue to receive those services, unless a specified notice is made by the Director of Finance to the Joint Legislative Budget Committee, in accordance with a designated section of the Government Code.

Existing law provides that when any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium, the county shall use county-only funds for the state and county share of any increase in the program, unless otherwise provided in the Budget Act or appropriated by statute.

Existing law establishes a formula with regard to provider wages or benefits increases negotiated or agreed to by a public authority or nonprofit consortium, and specifies the percentages required to be paid by the state and counties, beginning with the 2000-01 fiscal year, with regard to the nonfederal share of any increases.

This bill, notwithstanding the existing formula, would limit state participation to a total cost of wages up to $9.50 per hour and individual health benefits up to $0.60 per hour, commencing July 1, 2009, unless a specified notice is made by the Director of Finance to the Joint Legislative Budget Committee,

in accordance with a designated section of the Government Code.

This bill would authorize the State Department of Social Services to implement the changes made by this bill relating to the IHSS program through all-county letters or similar instructions from the director, pending the adoption of emergency regulations.

The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session for that purpose. The Governor issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on December 19, 2008.

This bill would state that it addresses the fiscal emergency declared by the Governor by proclamation issued on December 19, 2008, pursuant to the California Constitution.

This bill would declare that it is to take effect immediately as an urgency statute.

*The people of the State of California do enact as follows:*

* * *

SEC. 9. Section 12306.1 of the Welfare and Institutions Code is amended to read:

12306.1. (a) When any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium under Section 12301.6, then the county shall use county-only

funds to fund both the county share and the state share, including employment taxes, of any increase in the cost of the program, unless otherwise provided for in the annual Budget Act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect unless and until, prior to its implementation, the department has obtained the approval of the State Department of Health Care Services for the increase pursuant to a determination that it is consistent with federal law and to ensure federal financial participation for the services under Title XIX of the federal Social Security Act, and unless and until all of the following conditions have been met:

(1) Each county has provided the department with documentation of the approval of the county board of supervisors of the proposed public authority or nonprofit consortium rate, including wages and related expenditures. The documentation shall be received by the department before the department and the State Department of Health Care Services may approve the increase.

(2) Each county has met department guidelines and regulatory requirements as a condition of receiving state participation in the rate.

(b) Any rate approved pursuant to subdivision (a) shall take effect commencing on the first day of the month subsequent to the month in which final approval is received from the department. The

department may grant approval on a conditional basis, subject to the availability of funding.

(c) The state shall pay 65 percent, and each county shall pay 35 percent, of the nonfederal share of wage and benefit increases negotiated by a public authority or nonprofit consortium pursuant to Section 12301.6 and associated employment taxes, only in accordance with subdivisions (d) to (f), inclusive.

(d)(1) The state shall participate as provided in subdivision (c) in wages up to seven dollars and fifty cents ($7.50) per hour and individual health benefits up to sixty cents ($0.60) per hour for all public authority or nonprofit consortium providers. This paragraph shall be operative for the 2000-01 fiscal year and each year thereafter unless otherwise provided in paragraphs (2), (3), (4), and (5), and without regard to when the wage and benefit increase becomes effective.

(2) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to nine dollars and ten cents ($9.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the nine dollars and ten cents ($9.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative for the 2001-02 fiscal

year and each fiscal year thereafter, unless otherwise provided in paragraphs (3), (4), and (5).

(3) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to ten dollars and ten cents ($10.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the ten dollars and ten cents ($10.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenue, excluding transfers, for the year in which paragraph (2) became operative.

(4) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to eleven dollars and ten cents ($11.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the eleven dollars and ten cents ($11.10) per hour shall be used to fund wage increases or individual health benefits, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision

forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenues, excluding transfers, for the year in which paragraph (3) became operative.

(5) The state shall participate as provided in subdivision (c) in a total cost of wages and individual health benefits up to twelve dollars and ten cents ($12.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the twelve dollars and ten cents ($12.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenues, excluding transfers, for the year in which paragraph (4) became operative.

(6) Notwithstanding paragraphs (2) to (5), inclusive, the state shall participate as provided in subdivision (c) in a total cost of wages up to nine dollars and fifty cents ($9.50) per hour and in individual health benefits up to sixty cents ($0.60) per hour. This paragraph shall become operative on July 1, 2009.

(e)(1) On or before May 14 immediately prior to the fiscal year for which state participation is provided under paragraphs (2) to (5), inclusive, of subdivision (d), the Director of Finance shall certify to the Governor, the appropriate committees of the Legislature, and the department that the condition for each subdivision to become operative has been met.

(2) For purposes of certifications under paragraph (1), the General Fund revenue forecast, excluding transfers, that is used for the relevant fiscal year shall be calculated in a manner that is consistent with the definition of General Fund revenues, excluding transfers, that was used by the Department of Finance in the 2000-01 Governor's Budget revenue forecast as reflected on Schedule 8 of the Governor's Budget.

(f) Any increase in overall state participation in wage and benefit increases under paragraphs (2) to (5), inclusive, of subdivision (d), shall be limited to a wage and benefit increase of one dollar ($1) per hour with respect to any fiscal year. With respect to actual changes in specific wages and health benefits negotiated through the collective bargaining process, the state shall participate in the costs, as approved in subdivision (c), up to the maximum levels as provided under paragraphs (2) to (6), inclusive, of subdivision (d).

* * *

SEC. 11. Upon notification from the Director of Finance to the Joint Legislative Budget Committee

pursuant to Section 99030 of the Government Code, Sections 3 and 6 of this act and the amendments to Sections 12305.1 and 12306.1 of the Welfare and Institutions Codes, as contained in Sections 8 and 9 of this act shall be inoperative.

SEC. 12. (a) Notwithstanding the rulemaking provisions of the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, until emergency regulations are filed with the Secretary of State, the State Department of Social Services may implement Sections 8 and 9 of this act through all-county letters or similar instructions from the director. The department shall adopt emergency regulations, as necessary, to implement the specified provisions of this act, no later than December 1, 2010, unless notification of a delay is made to the Chair of the Joint Legislative Budget Committee prior to that date. Under no circumstances shall an adoption of emergency regulations be delayed, or the use of all-county letters or similar instructions be extended, beyond December 1, 2011.

(b) The adoption of regulations implementing the applicable provisions of this act shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for

filing with the Secretary of State and shall remain in effect for no more than 180 days, by which time the final regulations shall be adopted.

SEC. 13. This act addresses the fiscal emergency declared by the Governor by proclamation on December 19, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 14. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to enable statutory changes to be made in human services provisions at the earliest possible time, it is necessary that this act go into immediate effect.

## *INDEPENDENT LIVING*-TYPE SUPREMACY CLAUSE CASES

### I. CALIFORNIA CASES: INJUNCTION ISSUED[1]

1. *Cal. Hosp. Ass'n v. Maxwell-Jolly*, No. CV09-08642 (C.D. Cal.). California Hospital Association challenges 2009 amendments to Cal. Welf & Inst Code §§ 14105.191 and 14166.245, which imposed a statutory freeze on Medicaid reimbursements payments for some services provided by certain hospitals not under contract with the State, and which had the effect of reducing reimbursement to some hospitals by 10%, as preempted by 42 U.S.C. 1396a(a)(13)(A) and 1396a(a)(30)(A). On February 24, 2010, a federal district court enjoined the rate reductions.

**Cost of injunction**: $2.9 million/month in fiscal year 2009-2010; $4.4 million/month in fiscal year 2010-2011; over $3 million to date (Feb. 24, 2010-Apr. 1, 2010).

2. *Cal. Pharmacists Ass'n v. Maxwell-Jolly*, No. 2:09-cv-00722-CAS (C.D. Cal.); Nos. 09-55532, 09-55365 (9th Cir.). Medicaid providers and others challenge the September 2009 enactment/amendment of Cal. Welf. & Inst. Code §§ 14105.191, 14166.245(b)(2)(A), and 14166.245(c)(3)(B), which reduced Medicaid reimbursement payments to certain fee-for-service providers by 1-5%, as preempted by

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[1] Figures are estimates of total fund expenditures incurred due to injunctions based on best figures currently available to the California Department of Health Services.

42 U.S.C. §§ 1396a(a)(8), 1396a(a)(13)(A), and 1396a(a)(30)(A). This case is the subject of the current petition for certiorari.

**Cost of injunction**: $7-$8 million/month; in excess of $85 million to date (Mar. 9, 2009/Apr. 6, 2009 through Apr. 1, 2010).

3. *Cota v. Maxwell-Jolly*, No. C 09-3798 SBA (N.D. Cal.). Medicaid beneficiaries challenge California Welfare & Institutions Code §§ 14522.4, 14525.1 and 14526.2, which established new criteria for receipt of Adult Day Health Care (ADHC) services that were to take effect March 1, 2010, as preempted by, *inter alia*, the Medicaid Act, 42 U.S.C. § 1396a(a)(17). On February 24, 2010, a federal district court enjoined the new criteria from taking effect. *Cota v. Maxwell-Jolly*, No. C 09-3798 SBA, 2010 WL 693256 (N.D. Cal Feb. 24, 2010).

**Cost of injunction**: $839,000 in the current fiscal year; $31.8 million in the 2010-2011 fiscal year.

4. *Dominguez v. Schwarzenegger*, No. CV 09-2306 CW (N.D. Cal.); No. 09-16359 (9th Cir.) (formerly *Yang, Martinez*). Beneficiaries and unions that represent providers of In-Home Supportive Services challenge Cal. Welf & Inst. Code § 12306.1(d)(6), which reduced the State's level of contribution to wages and benefits that counties pay to providers under Medicaid effective July 1, 2009, as preempted by 42 U.S.C. § 1396a(a)(30)(A). This case is the subject of the current petition for certiorari.

**Cost of injunction**: $6.5 million/month; in excess of $58.5 million to date (July 1, 2009-Apr. 1, 2010).

5. *Indep. Living Ctr. of So. Cal. v. Maxwell-Jolly*, No. 2:08-cv 03315 CAS-MAN (C.D. Cal.); Nos. 08-56061, 08-56422, 08-56554 (9th Cir.). Medicaid providers and others challenge the February 2008 enactment of Cal. Welf. & Inst. Code § 14105.19(b)(1), which reduced by 10% reduction Medicaid reimbursement payments to certain fee-per-service providers, as preempted by 42 U.S.C. § 1396a(a)(30)(A). This case is the subject of a separately-pending petition for certiorari (No. 09-958).

**Cost of injunction**: no current monthly cost; approximately $332 million to date (through Feb. 1, 2010), plus approximately $70 million in retroactive relief pursuant to the Ninth Circuit's decision in July 2009, for a total in excess of $400 million. (Plaintiffs have indicated that they intend to seek additional retroactive relief that would exceed $250 million, bringing the State's potential liability to over $650 million.)

6. *Indep. Living Ctr. of So. Cal. v. Maxwell-Jolly*, No. 2:09-cv-00382-CAS-MAN (C.D. Cal.); Nos. 09-55692 (9th Cir.). Pharmacies challenge the September 2008 amendment of Cal. Welf & Inst. Code 14105.191(b)(2), which imposed a 1-5% reduction on Medicaid reimbursement payments to pharmaceutical providers, as preempted by 42 U.S.C.

§ 1396a(a)(30)(A). This case is the subject of the current petition for certiorari.

**Cost of injunction**: $11.54 million/month; $150 million to date (Mar. 1, 2009-Apr. 1, 2010).

7. *Santa Rosa Mem'l. Hosp. v. Maxwell-Jolly*, No. 3:08-cv-05173-SC (N.D. Cal.); No. 09-17633 (9th Cir.). Hospitals challenge the February 2008 amendment of Cal. Welf & Inst. Code §§ 14166.245(b)(1) and (c)(3)(A), which reduced Medicaid reimbursement payments to hospitals not under contract with the State by 10%, as preempted by 42 U.S.C. § 1396a(a)(30)(A). The district court enjoined the reductions on November 18, 2009. *Santa Rosa Mem'l Hosp. v. Maxwell-Jolly*, No. 08-5173 SC, 2009 WL 3925498 (N.D. Cal. Nov. 18, 2009). The appeal of the injunction has been fully briefed in the Ninth Circuit and is awaiting oral argument.

**Cost of injunction**: $1 million/month; $4.5 million to date (Nov. 18, 2009-Apr. 1, 2010).

8. *V.L. v. Wagner*, No. CV 09-04668 CW (N.D. Cal.); No. 09-17581 (9th Cir.). Medicaid providers and beneficiaries challenge Cal. Welf. & Inst. Code §§ 12309(e) and 12309.2, which provide amended need-based thresholds for receipt of In-Home Supportive Services under Medicaid, as preempted by 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(17), and 42 C.F.R. § 440.230(b). The district court enjoined these statutes on October 23, 2009. *V.L. v. Wagner*, No. C 09-04668 CW, 2009 WL 3486708 (N.D. Cal. Oct. 23, 2009); *see also* 2009 WL 4282079 (N.D. Cal. Nov. 25,

2009). The appeal of the injunction is currently being briefed in the Ninth Circuit.

**Cost of injunction**: $6.83 million/month; $34.16 million to date (Oct. 23, 2009-Apr. 1, 2010).

## II. CALIFORNIA CASES: NO INJUNCTION TO DATE

1. *AIDS Healthcare Found. v. Maxwell-Jolly*, No. CV09-08199 R PLAx (C.D. Cal.). Medicaid provider of prescription drugs challenges the 2009 enactment of Cal. Welf. & Inst. Code § 14105.46, which limits the manner in which certain drugs may be acquired for distribution to Medicaid beneficiaries under the 340B Program, as, *inter alia*, preempted by 42 U.S.C. §§ 1396a(a)(19) and 1396a(a)(30)(A). Briefing is underway in the district court.

2. *Anaheim Mem'l Med. Ctr. v Maxwell-Jolly*, No. 34-2009-80000373 (Cal. Super. Ct. (Sacramento)). Hospital challenges application of Act of Aug. 16, 2004 (SB 1103, § 32), ch. 228, 2004 Cal. Stat. 134-35, which imposed a statutory freeze on Medicaid reimbursement payments to hospitals not under contract with the State, as *inter alia* preempted by 42 U.S.C. §§ 1396a(a)(13)(A) and 1396a(a)(30)(A). This case is stayed during proceedings in another state court case that currently is on appeal.

3. *California Ass'n for Health Servs. at Home v. Shewry*, No. 2:08-cv-07045 CAS (C.D. Cal.). Providers of home health services challenge February and

September 2008 amendments to Cal. Welf. & Inst. Code, §§ 14105.19(a), (b)(1), (b)(2), (c)-(e), 14105.191(a)-(b)(1), (e)-(h), which reduced Medicaid payments to certain providers by 1-10%, as preempted by 42 U.S.C. § 1396a(a)(30)(A). This case is stayed during proceedings in *Indep. Living Ctr. v. Maxwell-Jolly*, No. 2:08-cv 03315 CAS-MAN (C.D. Cal.) (*Indep. Living*).

4. *California Hosp. Ass'n v. Maxwell-Jolly*, No. CV09-3694-CAS-MANx (C.D. Cal.). California Hospital Association challenges the portions of 2008 amendments to Cal. Welf. & Inst. Code §§ 14166.245 and 14091.3 that modified payment rates that Medi-Cal managed care plans pay for emergency and post-stabilization services to hospitals that do not have a contract with a Medi-Cal beneficiary's plan as pre-empted by, *inter alia*, 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30)(A), and 1396u-2(b).

5. *California Med. Ass'n v. Shewry*, No. BC390126 (Cal. Super. Ct. (Los Angeles)). Medicaid providers, beneficiaries, and others challenge the February 2008 enactment/amendment of Cal. Welf. & Inst. Code §§ 14105.19(b)(1) and 14166.245, which reduced by 10% Medicaid reimbursement payments to certain fee-for-services providers, as preempted by 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(13), 1396a(a)(30)(A), and 42 C.F.R. 447.204. The case is stayed during proceedings in *Indep. Living*.

6. *California Med. Transp. Ass'n v. Shewry*, No. 2:08-cv-07046 (C.D. Cal.). Providers of non-emergency

medical transportation services challenge February and September 2008 amendments to Cal. Welf. & Inst. Code §§ 14105.19(a), (b)(1), (b)(2), (c)-(e) and 14105.191(a)-(b)(1), (e)-(h), which reduced by 1-10% Medicaid reimbursement payments to various providers, as preempted by 42 U.S.C. § 1396a(a)(30)(A). The case is stayed during proceedings in *Indep. Living*.

7. *California Pharm. Ass'n v. Maxwell-Jolly*, No. CV-09-8200 CAS (C.D. Cal.); No. 09-57065 (9th Cir.). Pharmacies challenge a 4% reduction in published average wholesale price (AWP) data as determined by a third party vendor, and enactment/amendment of Cal. Welf. & Inst. Code §§ 14105.45 and 14105.455, alleging that they have the effect of reducing Medicaid reimbursement payments for pharmaceuticals, as preempted by 42 U.S.C. §§ 1396a(a)(5) and 1396a(a)(30)(A). Briefing is underway in the district court.

8. *Centinela Freeman Emergency Med. Assocs. v. Maxwell-Jolly*, No. BC406372 (Cal. Super. Ct. (Los Angeles)). Providers of emergency room services challenge the State's administration of the Medi-Cal Program, with respect to Medicaid reimbursement rates paid for emergency care services, as, *inter alia*, preempted by 42 U.S.C. § 1396a(a)(30)(A). The parties are waiting for oral argument to be rescheduled in state court.

9. *Gray Panthers of San Francisco v. Schwarzenegger*, No. 3:09-cv-02307-PJH (N.D. Cal.);

No. 09-16967 (9th Cir.). Medicaid providers and beneficiaries argued that Cal. Welf. & Inst. Code 14131.10(b)(1), which eliminated Medicaid coverage for certain enumerated services, was preempted by the American Recovery and Reinvestment Act of 2009, H.R. 1, 111th Cong., Pub. L. No. 111-5 (1st Sess. 2009) §§ 5000(a), 5001(f). The district court denied plaintiffs' motion for a preliminary injunction and dismissed the lawsuit. *See Gray Panthers of San Francisco v. Schwarzenegger*, NO. C 09-2307 PJH, 2009 WL 2880555 (N.D. Cal. Sept. 01, 2009); *see also* 2009 WL 2880486 (N.D. Cal. Sept. 01, 2009). Plaintiffs voluntarily dismissed their appeal.

10. *Morales v. Wagner*, Nos. CPF 05-505687, 05-505783, 05-505888 (Cal. Super. Ct. (San Francisco)). An amended petition for writ of mandate, filed on November 4, 2009, asserts a new Supremacy Clause-based challenge to a state statute governing the setting of foster care maintenance rates for children in the foster care system who have developmental disabilities. Petitioners contend that the state statute, Cal. Welf. & Inst. Code § 11464, is preempted by 42 U.S.C. §§ 672(a) and 675(4)(A). District courts around the country disagree on whether the federal statutes at issue create rights enforceable under § 1983, and the Ninth Circuit has not yet reached the issue.

11. *Nat'l Ass'n of Chain Drug Stores, Inc. v. Schwarzenegger*, No. CV09-7097 CAS (C.D. Cal.); No. 09-57051 (9th Cir.). Pharmacies challenge a 4% reduction in published average wholesale price (AWP) data that is developed by a third party vendor, which

has the effect of reducing Medicaid reimbursement payments for pharmaceuticals, as preempted by 42 U.S.C. §§ 1396a(a)(5) and 1396a(a)(30)(A). The district court denied plaintiffs' motion for a preliminary injunction in December 7, 2009. Briefing on the denial of the injunction is underway in the Ninth Circuit.

12. *Putz v. Schwarzenegger*, No. CV-10-0344 (N.D. Cal.). Medicaid recipients and other entities challenge reductions in funding mandated by the legislature and Governor for public authorities that facilitate and support the provision of In-Home Supportive Services under the State's Medicaid program, enacted in July 2009, as preempted by 42 U.S.C. § 1396a(a)(30)(A). Plaintiffs filed their complaint on January 25, 2010, and district court proceedings are underway.

13. *Santa Rosa Mem'l Hosp. v. Maxwell-Jolly*, No. CPF-09-509658 (Cal. Super. Ct. (San Francisco)). Hospitals alleged that the February 2008 enactment/amendment of Cal. Welf. & Inst. Code §§ 14105.19 and 14166.245, which reduced by 10% Medicaid reimbursement payments to, *inter alia*, hospitals not under contract with the State, are preempted by 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(13)(A), 1396a(a)(30)(A), and 1396r-4(a)(1). This case is effectively stayed by agreement of the parties during proceedings in *Santa Rosa Mem'l Hosp. v.Maxwell-Jolly*, No. 3:08-cv-05173-SC (N.D. Cal.); No. 09-17633 (9th Cir.).

## III. NONCALIFORNIA CASES

1. *Affiliates, Inc. v. Armstrong*, No. CV-09-149-BLW, 2009 WL 1197341 (D. Idaho Apr. 30, 2009). Plaintiffs challenged a modification in a procedure by which state determines Medicaid reimbursement for support and training services provided to direct caregivers of persons with developmental disabilities as preempted by 42 U.S.C. § 1396a(a)(30)(A). The district court entered a temporary restraining order and held that plaintiffs had asserted a claim that is "actionable under the Supremacy Clause" even though § 1396a(a)(30)(A) does not confer a "substantive" right on providers. *Id.* at *4 (citing *Independent Living Center*). On June 11, 2009, the parties stipulated to a permanent injunction and, on January 22, 2010, the district court entered a permanent injunction.

2. *Ariz. Ass'n of Providers for Persons with Disabilities v. State*, No. 1 CA-CV 09-0167, 219 P.3d 216 (Ariz. Ct. App. 2009). Developmentally disabled Medicaid beneficiaries and service providers challenged 10% reimbursement rate reduction as preempted by 42 U.S.C. § 1396a(a)(30)(A). The Court of Appeal vacated a trial court injunction after holding, based on *Independent Living Center*, that "[t]here is a private cause of action under the Supremacy Clause of the United States Constitution for a violation of Title XIX's network requirements." *Id.* at 228 n.9.

3. *Carter v. Gregoire*, No. C09-5393BHS, ___ F.Supp.2d ___, 2009 WL 2486160 (W.D. Wash. Aug.

12, 2009), *aff'd*, No. 09-35755, 2010 WL 235264 (9th Cir. Jan. 20, 2010); *see also* 2009 WL 1916069 (W.D. Wash. July 1, 2009). Family providers of personal care services challenged change in law requiring family member caregivers to act as independent contractors, instead of home care agency employees, alleging that the law had the effect of reducing the compensation they received for providing such services, as preempted by *inter alia*, 42 U.S.C. §§ 1396a(a)(10)(B), 1396a(a)(23)(A), and 1396a(a)(30)(A). The district court initially granted a temporary restraining order, but then denied plaintiffs' motion for preliminary injunction on the merits (after citing the Supremacy Clause), and the Ninth Circuit affirmed. Plaintiffs voluntarily dismissed case on March 4, 2010.

4. *Christ the King Manor, Inc. v. Sebelius*, No. 9-CV-02007-JEJ (M.D. Pa.). On October 15, 2009, certified nursing facility providers filed a lawsuit challenging the federal government's approval of State Plan Amendments relating to changes to Pennsylvania's methods and standards for payments to nursing facility providers under the State Medicaid Program. Plaintiffs contend that the changes are, *inter alia*, preempted by 42 U.S.C. § 1396a(a)(30)(A). Pennsylvania has advised that briefing is underway in the district court.

5. *Conn. Ass'n of Health Care Facilities, Inc. v. Rell* (D. Conn.). On January 28, 2010, an advocacy group for providers of long-term subacute and rehabilitative services filed a lawsuit challenging

legislative action that it claims freezes Medicaid payments to such facilities at the rates currently in effect until July 1, 2011, effectively reversing increases that the facilities had anticipated. Plaintiffs contend that the freeze is preempted by 42 U.S.C. §§ 1396a(a)(13)(A) and 1396a(a)(30)(A).

6. *G., ex rel., K. v. Hawai'i, Dep't of Human Servs.*, Nos. 08-00551 ACK-BMK, 09-00044 ACK-BMK, 2009 WL 1322354, at *19 n.16 (D. Hawai'i May 11, 2009). Plaintiffs challenged a state requirement that Medicaid beneficiaries enroll with certain health-care entities as a condition of receiving Medicaid benefits in connection with the Hawai'i's managed-care program, as preempted by 42 U.S.C. §§ 1396u-2(a)(1)(A)(i), 1396b (m)(1), 1396u-2(a)(1)(A)(ii), and 1396u-2(b)(5). On May 11, 2009, the district court granted defendants' motion to dismiss these claims finding no "conflict" preemption, after citing *Independent Living Center* for the proposition that plaintiffs had "standing" to bring them. *Id.* at 19 & n.16.

7. *H.S. v. Parkinson*, No. ___ (Kan.). On March 12, 2010, advocacy groups and Medicaid beneficiaries filed a petition for writ of mandamus in the Kansas Supreme Court contending that $10 million in recent Medicaid funding cuts are, *inter alia*, preempted by 42 U.S.C. §§ 1396a(a)(17) and 1396a(a)(30)(A).

8. *Inclusion, Inc. v. Armstrong*, No. 09-CV-00634 BLW (D. Idaho). On December 7, 2009, providers of services to Medicaid beneficiaries with developmental disabilities filed a lawsuit challenging reimbursement

rates that have been in place since 2003 for residential habilitation and developmental therapy services as preempted by 42 U.S.C. § 1396a(a)(30)(A).

9. *Minnesota Pharmacists Ass'n v. Pawlenty*, No. 09-2723 (DWF/RLE), 2010 WL 561473 (D. Minn. Feb. 10, 2010). Pharmacies and beneficiaries seek to enjoin reductions in the reimbursement rates that the State of Minnesota pays pharmacies for brand-name ("single-source") pharmaceutical drugs covered by the State's Medicaid program as preempted by, *inter alia*, 42 U.S.C. § 1396a(a)(30)(A). On February 10, 2010, the district court denied a motion for preliminary injunction, but denied in part a motion for judgment on the pleadings, holding that plaintiffs had stated a claim under the Supremacy Clause. *Id.* at *12-17.

10. *Nat'l Ass'n of Chain Drug Stores, Inc. v. Markell*, No. 09-425 SLR (D. Del.). On June 9, 2009, pharmacies filed a lawsuit challenging a reduction in reimbursement rates for single-source drugs from AWP – 14% to AWP – 16% as preempted by 42 U.S.C. § 1396a(a)(30)(A). Delaware reports that this case settled in August 2009.

11. *Pharmacists Soc'y of the State of N.Y. v. Patterson*, No. 09-CV-01100 (N.D.N.Y.). Pharmacists challenge reduction in reimbursement payments under Medicaid as preempted by 42 U.S.C. § 1396a(a)(30)(A). On January 14, 2010, the district court denied plaintiffs' motion for a preliminary injunction.

12. *Suzman v. Harvey*, No. 07-217, 2008 WL 2945430 (D. Me. Jul. 25, 2008), *report and recommendation adopted by* 2008 WL 3929586 (D. Me. Aug 27, 2008). A recipient of personal care attendant services challenged the state's decision to reduce the hours of services he receives each week under Medicaid as preempted by 42 U.S.C. § 1396a(a)(17)(D). The trial court dismissed plaintiff's claim under 42 U.S.C. § 1983, but declined to dismiss his Supremacy Clause claim. 2008 WL 2945430, at *3-4. Maine advises that the parties subsequently stipulated to dismissal of the case.

13. *Unity Serv. Coord., Inc. v. Armstrong*, No. 09-CV-00639-BLW (D. Idaho). On December 9, 2009, providers of Service Coordination benefits to Medicaid beneficiaries filed a lawsuit challenging a recent (nonstatutory) rate methodology change (adoption of a fee-for-service incremental rate in place of the previously-used bundled daily rate) in the services they provide as preempted by 42 U.S.C. § 1396a(a)(30)(A).

14. *Wash. Health Care Ass'n v. Dreyfus*, No. C09-5395-RBL (W.D. Wash.). On June 30, 2009, the association of for-profit nursing facilities in Washington and several individual facilities filed a lawsuit challenging a scheduled cut in Medicaid payment rates as preempted by 42 U.S.C. § 1396a(a)(30)(A). A federal judge issued a temporary restraining order to prevent the cuts from taking effect. The parties have agreed to put the lawsuit on hold while they try to reach a legislative solution.

15. *Wash. State Pharmacy Ass'n v. Gregoire*, No. C09 5174-BHS, 2009 WL 1259632 (W.D. Wash. Mar. 31, 2009). Pharmacy association challenged six percentage point reduction in Medicaid reimbursement rates as preempted by 42 U.S.C. § 1396a(a)(30)(A). On March 31, 2009, a district court enjoined the rate reductions.

16. *Wash. State Pharmacy Ass'n v. Gregoire*, No. C09-1377-RAJ (W.D. Wash.). On September 29, 2009, a pharmacy association and other entities filed a lawsuit challenging the state's drug-ingredient payment amounts, in the wake of a reduction in AWP as determined by a third party vendor, as preempted by 42 U.S.C. § 1396a(a)(30)(A). On February 10, 2010, the district court entered an order holding that plaintiff has standing to sue under the Supremacy Clause but denying plaintiff's motion for a preliminary injunction.

17. *Women's Hosp. Found. v. Townsend*, No. 07-711-JJB-DLD, 2008 WL 2743284, at *11 (M.D. La. July 10, 2008). Hospital and Medicaid beneficiaries challenge Medicaid reimbursement rates as preempted by 42 U.S.C. § 1396a(a)(30)(A) and Medicaid regulations. The district court held that plaintiffs stated a cause of action under the Supremacy Clause and declined to dismiss the complaint. *Id.* at *11.